MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.

- No action has been taken on anything herein contained, and it is informational only.

- Only those items that have been acted on finally by the House can be considered official.

- REMINDER: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.
UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with “abortion” and running to “women”; the former topic was assigned the number 5, and “women” was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will generally have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- “H” – for statements that one would consider positional or philosophical on an issue
- “D” – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- “G” – for statements related to AMA governance
- “E” – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at ama-assn.org/go/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the Proceedings, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

- BOT – Board of Trustees
- CME – Council on Medical Education
- CCB – Council on Constitution and Bylaws
- CMS – Council on Medical Service
- CEJA – Council on Ethical and Judicial Affairs
- CSAPH – Council on Science and Public Health
- CLRPD – Council on Long Range Planning and Development

If a resolution was involved, “Res” is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

<table>
<thead>
<tr>
<th>Category Number</th>
<th>Category Name</th>
<th>Category Number</th>
<th>Category Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.000</td>
<td>Abortion</td>
<td>10.000</td>
<td>Accident Prevention/Unintentional Injuries</td>
</tr>
<tr>
<td>15.000</td>
<td>Accident Prevention: Motor Vehicles</td>
<td>20.000</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>25.000</td>
<td>Aging</td>
<td>30.000</td>
<td>Alcohol and Alcoholism</td>
</tr>
<tr>
<td>35.000</td>
<td>Allied Health Professions</td>
<td>40.000</td>
<td>Armed Forces</td>
</tr>
<tr>
<td>45.000</td>
<td>Aviation Medicine</td>
<td>50.000</td>
<td>Blood</td>
</tr>
<tr>
<td>55.000</td>
<td>Cancer</td>
<td>60.000</td>
<td>Children and Youth</td>
</tr>
<tr>
<td>65.000</td>
<td>Civil and Human Rights</td>
<td>70.000</td>
<td>Coding and Nomenclature</td>
</tr>
<tr>
<td>75.000</td>
<td>Contraception</td>
<td>80.000</td>
<td>Crime</td>
</tr>
<tr>
<td>85.000</td>
<td>Death and Vital Records</td>
<td>90.000</td>
<td>Disabled</td>
</tr>
<tr>
<td>95.000</td>
<td>Drug Abuse</td>
<td>100.000</td>
<td>Drugs</td>
</tr>
<tr>
<td>105.000</td>
<td>Drugs: Advertising</td>
<td>110.000</td>
<td>Drugs: Cost</td>
</tr>
<tr>
<td>115.000</td>
<td>Drugs: Labeling and Packaging</td>
<td>120.000</td>
<td>Drugs: Prescribing and Dispensing</td>
</tr>
<tr>
<td>125.000</td>
<td>Drugs: Substitution</td>
<td>130.000</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>135.000</td>
<td>Environmental Health</td>
<td>140.000</td>
<td>Ethics</td>
</tr>
<tr>
<td>145.000</td>
<td>Firearms: Safety and Regulation</td>
<td>150.000</td>
<td>Foods and Nutrition</td>
</tr>
<tr>
<td>155.000 Health Care Costs</td>
<td>160.000 Health Care Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>165.000 Health Care/System Reform</td>
<td>170.000 Health Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>175.000 Health Fraud</td>
<td>180.000 Health Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>185.000 Health Insurance: Benefits and Coverage</td>
<td>190.000 Health Insurance: Claim Forms and Claims Processing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>195.000 Health Maintenance Organizations</td>
<td>200.000 Health Workforce</td>
<td></td>
<td></td>
</tr>
<tr>
<td>205.000 Health Planning</td>
<td>210.000 Home Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>215.000 Hospitals</td>
<td>220.000 Hospitals: Accreditation Standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>225.000 Hospitals: Medical Staff</td>
<td>230.000 Hospitals: Medical Staff - Credentialing and Privileges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>235.000 Hospitals: Medical Staff - Organization</td>
<td>240.000 Hospitals: Reimbursement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>245.000 Infant Health</td>
<td>250.000 International Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>255.000 International Medical Graduates</td>
<td>260.000 Laboratories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>265.000 Legal Medicine</td>
<td>270.000 Legislation and Regulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>275.000 Licensure and Discipline</td>
<td>280.000 Long-Term Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>285.000 Managed Care</td>
<td>290.000 Medicaid and State Children's Health Insurance Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>295.000 Medical Education</td>
<td>300.000 Medical Education: Continuing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>305.000 Medical Education: Financing and Support</td>
<td>310.000 Medical Education: Graduate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>315.000 Medical Records and Patient Privacy</td>
<td>320.000 Medical Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>330.000 Medicare</td>
<td>335.000 Medicare: Carrier Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>340.000 Medicare: PRO</td>
<td>345.000 Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>350.000 Minorities</td>
<td>355.000 National Practitioner Data Bank</td>
<td></td>
<td></td>
</tr>
<tr>
<td>360.000 Nurses and Nursing</td>
<td>365.000 Occupational Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>370.000 Organ Donation and Transplantation</td>
<td>373.000 Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>375.000 Peer Review</td>
<td>380.000 Physician Fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>383.000 Physician Negotiation</td>
<td>385.000 Physician Payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>390.000 Physician Payment: Medicare</td>
<td>400.000 Physician Payment: Medicare - RBRVS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>405.000 Physicians</td>
<td>406.000 Physician-Specific Health Care Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>410.000 Practice Parameters</td>
<td>415.000 Preferred Provider Arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>420.000 Pregnancy and Childbirth</td>
<td>425.000 Preventive Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>430.000 Prisons</td>
<td>435.000 Professional Liability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>440.000 Public Health</td>
<td>445.000 Public Relations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>450.000 Quality of Care</td>
<td>455.000 Radiation and Radiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>460.000 Research</td>
<td>465.000 Rural Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>470.000 Sports and Physical Fitness</td>
<td>475.000 Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>478.000 Technology - Computer</td>
<td>480.000 Technology - Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>485.000 Television</td>
<td>490.000 Tobacco Use, Prevention and Cessation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>495.000 Tobacco Products</td>
<td>500.000 Tobacco: AMA Corporate Policies and Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>505.000 Tobacco: Federal and International Policies</td>
<td>510.000 Veterans Medical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>515.000 Violence and Abuse</td>
<td>520.000 War</td>
<td></td>
<td></td>
</tr>
<tr>
<td>525.000 Women</td>
<td>600.000 Governance: AMA House of Delegates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>605.000 Governance: AMA Board of Trustees and Officers</td>
<td>610.000 Governance: Nominations, Elections, and Appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>615.000 Governance: AMA Councils, Sections, and Committees</td>
<td>620.000 Governance: Federation of Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>625.000 Governance: Strategic Planning</td>
<td>630.000 Governance: AMA Administration and Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>635.000 Governance: Membership</td>
<td>640.000 Governance: Advocacy and Political Action</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter in parenthesis following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Amendments to Constitution and Bylaws begin with 1, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Sunday, June 10, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. Memorandum from the Speaker
2. Understanding the Recording of American Medical Association Policy
3. Declaration of Professional Responsibility - Medicine's Social Contract with Humanity
4. Delegate / Alternate Delegate Job Description, Roles and Responsibilities
5. Seating Allocation and Seating Chart for the House of Delegates
6. Hotel Maps
7. Official Call to the Officers and Members of the AMA
   Listing of Delegates and Alternate Delegates
   Officials of the Association and AMA Councils
   House of Delegates Reference Committee Members
8. Note on Order of Business
9. Summary of Fiscal Notes

FOLLOWING COLLATED BY REFERRAL

10. Report(s) of the Board of Trustees - Gerald E. Harmon, MD, Chair
    01 Annual Report (F)
    02 New Specialty Organizations Representation in the House of Delegates (Amendments to C&B)
    03 2017 Grants and Donations (Info. Report)
    04 AMA 2019 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 2017 (Info. Report)
    08 Annual Update on Activities and Progress in Tobacco Control: March 2017 Through February 2018
        (Info. Report)
    09 Council on Legislation Sunset Review of 2008 House Policies (B)
    10 Over-the-Counter Contraceptive Drug Access (E)
    11 Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States (D)
12 Advocacy for Seamless Interface Between Physician Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs (B)
13 Mergers of Secular and Religiously Affiliated Health Care Institutions and Their Impact on Patient Care and Access to Services (Amendments to C&B)
14 Integration of Drug Price Information into Electronic Medical Records / Barriers to Price Transparency / Bidirectional Communication for EHR Software and Pharmacies / Health Plan, Pharmacy, Electronic Health Records Integration (B)
15 Advanced Practice Registered Nurse Compact (B)
16 Protection of Clinician-Patient Privilege (B)
17 Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care (B)
18 Medical Liability Coverage Through the Federal Tort Claims Act (B)
19 Health Information Technology Principles (B)
20 Anti-Harassment Policy (F)
21 Ownership of Patient Data (Info. Report)
22 In-Flight Emergencies (E)
23 Healthcare as a Human Right (Amendments to C&B)
24 Appropriate Placement of Transgender Prisoners (Amendments to C&B)
25 Recognition of Physician Orders for Life Sustaining Treatment Forms (Amendments to C&B)
26 Revision of Researcher Certification and Institutional Review Board Protocols (Amendments to C&B)
27 Policy and Economic Support for Early Child Care (D)
28 Mandatory Public Health Reporting of Law-Enforcement-Related Injuries and Deaths (D)
29 Support for Service Animals, Emotional Support Animals, Animals in Healthcare and Medical Benefits of Pet Ownership (E)
30 In-Flight Emergencies (E)
31 Physician Burnout and Wellness Challenges, Physician and Physician Assistant Safety Net, Identification and Reduction of Physician Demoralization (G)
32 Studying Healthcare Institutions that Provide Child Care Services (Info. Report)
33 Plan for Continued Progress Toward Health Equity (F)
34 AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies (F)
35 Model Hospital Medical Staff Bylaws (F)
36 Management of Physician and Medical Student Stress (Info. Report)
37 Eliminate the Requirement of H&P Update (G)
38 Timely Referral to Pain Management Specialist (E)
39 Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models (G)
40 Medicare Coverage of Services Provided by Proctored Medical Students (A)
41 Augmented Intelligence in Health Care (B)

11. Report(s) of the Council on Constitution and Bylaws - Colette R. Willins, MD, Chair
   01 CCB Sunset Review of 2008 House Policies (Amendments to C&B)

12. Report(s) of the Council on Ethical and Judicial Affairs - Dennis S. Agliano, MD, Chair
   01 Competence, Self-Assessment and Self-Awareness (Amendments to C&B)
   02 Mergers of Secular and Religiously Affiliated Health Care Institutions (Amendments to C&B)
   03 Medical Tourism (Amendments to C&B)
13. Opinion(s) of the Council on Ethical and Judicial Affairs - Dennis S. Agliano, MD, Chair
   01 Ethical Physician Conduct in the Media (Info. Report)

14. Report(s) of the Council on Long Range Planning and Development - Glenn A. Loomis, MD, Chair
   01 A Primer on Artificial and Augmented Intelligence (Info. Report)

15. Report(s) of the Council on Medical Education - Lynne M. Kirk, MD, Chair
   01 Council on Medical Education Sunset Review of 2008 House of Delegates Policies (C)
   02 Update on Maintenance of Certification and Osteopathic Continuous Certification (C)
   03 Expanding UME Without Concurrent GME Expansion (C)
   04 Evaluation of Clinical Documentation Training (C)
   05 Study of Declining Native American Medical Student Enrollment (Info. Report)
   06 Mental Health Disclosures on Physician Licensing Applications (C)

16. Report(s) of the Council on Medical Service - Paul A. Wertsch, MD, Chair
   01 Council on Medical Service Sunset Review of 2008 AMA House Policies (A)
   02 Improving Affordability in the Health Insurance Exchanges (A)
   03 Ensuring Marketplace Competition and Health Plan Choice (A)
   04 Health Plans' Medical Advice (G)
   05 Financing of Long-Term Services and Supports (G)
   06 Integrating Precision Medicine into Alternative Payment Models (G)
   07 Insulin Affordability (A)
   08 Addressing the Site-of-Service Differential (Info. Report)

17. Report(s) of the Council on Science and Public Health - Robert A. Gilchick, MD, Chair
   01 CSAPH Sunset Review of 2008 House of Delegates Policies (D)
   02 Drug Shortages: Update (E)
   03 Prescription Drug Donation (E)
   04 The Physician's Role in Firearm Safety (D)
   05 Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking (D)

18. Joint Report(s)
   01 CMS/CSAPH Joint Report - Coverage for Colorectal Cancer Screening (A)

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

20. Resolutions
   001 Discriminatory Policies that Create Inequities in Health Care (Amendments to C&B)
   002 FMLA-Equivalent for LGBT Workers (Amendments to C&B)
   003 Proposing Consent for De-Identified Patient Information (Amendments to C&B)
   004 Patient-Reported Outcomes in Gender Confirmation Surgery (Amendments to C&B)
   005 Decreasing Sex and Gender Disparities in Health Outcomes (Amendments to C&B)
   006 Living Donor Protection Act of 2017 (HR 1270) (Amendments to C&B)
007 Oppose the Criminalization of Self-Induced Abortion (Amendments to C&B)
008 Health Care Rights of Pregnant Minors (Amendments to C&B)
009 Improving and Increasing Clarity and Consistency Among AMA Induced Abortion Policies (Amendments to C&B)
010 Gender Equity in Compensation and Professional Advancement (Amendments to C&B)
011 Women Physician Workforce and Gender Gap in Earnings - Measures to Improve Equality (Amendments to C&B)
012 Costs to Kidney Donors (Amendments to C&B)
013 Opposing Surgical Sex Assignment of Infants with Differences of Sex Development (Amendments to C&B)
014 Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms (Amendments to C&B)
015 Human Trafficking / Slavery Awareness (Amendments to C&B)
101 Medicaid Reform (A)
102 Effectiveness of Risk Assessment Models in Representing Healthcare Resources Expended for Infants and Children (A)
103 Oppose Medicaid Eligibility Lockout (A)
104 Emergency Out of Network Services (A)
105 Use of High Molecular Weight Hyaluronic Acid (A)
106 Prohibit Retrospective ER Coverage Denial (A)
107 Opposition to Medicaid Work Requirement (A)
108 Expanding AMA's Position on Healthcare Reform Options (A)
109 Medicaid Coverage of Fitness Facility Memberships (A)
110 Return to Prudent Layperson Standard for Emergency Services (A)
111 Medicare Coverage for Dental Services (A)
112 Enabling Attending Physicians to Waive the Three-midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs (A)
113 Survivorship Care Plans (A)
114 Inclusion of Bundled Payments Care Improvement (BPCI) Post-Acute only Model 3 in Advanced BPCI (A)
201 Removing Barriers to Obesity Treatment (B)
202 Universal and Standardized Protocols for EHR Data Transition (B)
203 Updating Federal Food Policy to Improve Nutrition and Health (B)
204 Opposition to Mandated Proficiency in EHR for Licensure (B)
205 Augmented Intelligence (B)
206 Appropriate Use of Telehealth Services (B)
207 Quality Improvement Requirements (B)
208 Prior Authorization Requirements for Post-Operative Opioids (B)
209 Substance Use Disorders During Pregnancy (B)
210 Banning the Sale of Bump Stocks (B)
211 Clarification from U.S. Department of Justice Regarding Federal Enforcement of Medical Marijuana Laws (B)
212 Value-Based Payment System (B)
213 Utilization Review (B)
214 Strengthening the Background Check System for Firearm Sales (B)
215 Regulation of Hospital Advertising (B)
216 FDA Conflict of Interest (B)
217 Reforming the Orphan Drug Act (B)
218 Considering Feminine Hygiene Products as Medical Necessities (B)
219 Improving Medicare Patients' Access to Kidney Transplantation (B)
220 Ban on Semi-Automatic Assault Weapons and High Capacity Ammunition Magazines (B)
221 Maintaining Validity and Comprehensiveness of U.S. Census Data (B)
222 Evidence Based Treatment in Substance Abuse Treatment Facilities (B)
223 Treating Opioid Use Disorder in Hospitals (B)
224 Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions (B)
225 Pharmacy Benefit Managers Impact on Patients (B)
226 Model State Legislation for Routine Preventative Prostate Cancer Screening for Men Ages 55-69 (B)
227 An Optional National Prescription Drug Formulary (B)
228 Medicare Quality Incentives (B)
229 Green Card Backlog for Immigrant Doctors on H-1B Visa (B)
230 Opposition to Funding Cuts for Programs that Impact the Health of Populations (B)
231 Online Controlled Drugs (B)
232 Recording Law Reform (B)
233 Support for Reauthorization of the Supplemental Nutrition Assistance Program (B)
234 Support for Primary Care Enhancement Act (B)
235 Hospital Consolidation (B)
236 Reducing MIPS Reporting Burden (B)
237 Safe and Efficient E-Prescribing (B)
238 Reform of Pharmaceutical Pricing: Negotiated Payment Schedules (B)
239 Treating Opioid Use Disorder in Hospitals (B)
240 Treating Opioid Use Disorder in Treatment Facilities (B)
241 Accuracy and Accountability of Physician Compensation Reporting by Drug and Device Companies (B)
242 Pharmacy Benefit Managers and Compounded Medications (B)
243 Report Health Care Provider Sex Crimes to Law Enforcement (B)
301 Protecting Medical Trainees from Hazardous Exposure (C)
302 For-Profit Medical Schools or Colleges (C)
303 Fellowship Start Date (C)
304 Persons With Intellectual and Developmental Disabilities Designated as a Medically Underserved Population (C)
305 Standardization of Medical Licensing Time Limits Across States (C)
306 Sex and Gender Based Medicine (C)
307 Healthcare Finance in the Medical School Curriculum (C)
308 Foreign Trained IMGs Obtaining a U.S. License Without U.S. Residency (C)
309 Foreign Trained IMGs Competency-Based Specialty Exam Without U.S. Residency (C)
310 U.S. Institutions With Restricted Medical Licensure (C)
307 Opioid Education for New Trainees (C)
312 Suicide Awareness Training (C)
313 Financial Literacy for Medical Students and Residents (C)
314 Board Certification Changes Impact Access to Addiction Medicine Specialists (C)
315 Peer-Facilitated Intergroup Dialogue (C)
316 End "Part 4 Improvement in Medical Practice" Requirement for ABMS MOC (C)
401 Danger from Bright Vehicle Headlights (D)
402 Schools as Gun-Free Zones (D)
403 School Safety and Mental Health (D)
404 Emphasizing the Human Papillomavirus Vaccines as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic (D)
405 Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data (D)
406 Support for Public Health Violence Prevention Programs (D)
407 Support for Research of Boxes for Babies' Sleeping Environment (D)
408 Ending Money Bail to Decrease Burden on Lower Income Communities (D)
409 Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities (D)
410 Opposition to Measures that Criminalize Homelessness (D)
411 Reporting Child Abuse in Military Families (D)
412 Reducing the Use of Restrictive Housing in Prisoners with Mental Illness (D)
413 Improving Safety and Health Code Compliance in School Facilities (D)
414 Sex Education Materials for Students with Limited English Proficiency (D)
415 Reducing Gun Violence in America (D)
416 Medical Respite Care for Homeless Adults (D)
417 Reducing Disparities in Obstetric Outcomes, Maternal Morbidity, and Prenatal Care (D)
418 A Guide for Best Health Practices for Seniors Living in Retirement Communities (D)
419 Violence Prevention (D)
420 Mandatory Influenza Vaccination Policies for Healthcare Workers (D)
421 Product Date Labels (D)
422 School Drinking Water Quality Testing, Monitoring, and Maintenance (D)
423 Grill Brush Warning (D)
424 Rape and Sexual Abuse on College Campuses (D)
425 Hospital Food Labeling (D)
501 Synthetic Cannabinoids (E)
502 Expedited Prescription CBD Drug Rescheduling (E)
503 Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians (E)
504 Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex) (E)
505 Researching Drug Facilitated Sexual Assault Testing (E)
506 Non-Therapeutic Gene Therapies (E)
507 Opioid Treatment Programs Reporting to Prescription Monitoring Programs (E)
508 Reintroduction of Mitochondrial Donation in the United States (E)
509 Opposing the Classification of Cannabidiol as a Schedule 1 Drug (E)
510 Alcohol Use and Cancer (E)
511 Education for Recovering Patients on Opiate Use After Sobriety (E)
512 Physician and Patient Education About the Risk of Synthetic Cannabinoid Use (E)
513 Hand Sanitizer Effectiveness (E)
514 Effects of Virtual Reality on Human Health (E)
515 Information Regarding Animal-Derived Medications (E)
516 Waste Incinerator Ban (E)
517 Impact of Natural Disasters on Pharmaceutical Supply and Public Health (E)
21. Information Statement

01 airRx www.airrxmedical.com (Information Statement)
**DECLARATION OF PROFESSIONAL RESPONSIBILITY:**

**MEDICINE’S SOCIAL CONTRACT WITH HUMANITY**

**Preamble**

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

**Declaration**

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.
2. Refrain from supporting or committing crimes against humanity and condemn all such acts.
3. Treat the sick and injured with competence and compassion and without prejudice.
4. Apply our knowledge and skills when needed, though doing so may put us at risk.
5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
7. Educate the public and polity about present and future threats to the health of humanity.
8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association in San Francisco, California on December 4, 2001
Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications
   • AMA member.
   • Elected or selected by the principal governing body or the membership of the sponsoring organization.
   • The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
   • Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
   • Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
   • Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
   • Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
   • Serve as an advocate for patients to improve the health of the public and the health care system.
   • Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
   • Actively recruit new AMA members and help retain current members.
   • Participate in the AMA Membership Outreach Program.
<table>
<thead>
<tr>
<th>SEAT</th>
<th>COLORADO - 9</th>
<th>ANESTHESIOLOGY - 9</th>
<th>TELLERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T T</td>
<td>OMA LAZARUS</td>
<td>T T</td>
</tr>
<tr>
<td>2</td>
<td>MT - 1 ID - 1 AK - 1 COLORADO RI - 2 VT - 1 ANESTHESIOLOGY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>WASHINGTON - 4 OREGON - 3 CONNECTICUT - 5 NH - 2 TIBLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>NEW MEXICO - 3 UTAH - 4 MASSACHUSETTS - 16 MAINE - 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>NEVADA - 2 HAWAII - 2 ARIZONA - 9 MASSACHUSETTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>ARIZONA X MASSACHUSETTS UROLOGY - 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>CALIFORNIA - 32 SECTIONS - 11 UROLOGY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>CALIFORNIA X RSNA - 3 ONCOLOGY - 1 ASCO - 1 ASCO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>CALIFORNIA X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>RIBEIRA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>CALIFORNIA X INFECTIONMEDIC - 3 ILLINOIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>BRISTOW FLEETED CORLIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>PATHOLOGY 9 CHEST PHYSICIANS - 3 THORACIC - 2 IN ILLINOIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>USCAP USCAP ACCP ACCP ATS ATS STEEN ACML ACRO AMVIA ASMBP SNMBP AMDA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>CAP CAP CAP ACCP ACCP ASBM NAME NMA RESIDENT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 16   | AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP AAP A
Welcome to Hyatt Regency Chicago. Meeting rooms, ballrooms, restaurants and guest amenities are listed in alphabetical order and color coded by floor. For help, dial Guest Services at Extension 4460.

EAST TOWER

WEST TOWER

Hyatt Regency Chicago
Guest Map

Elevators, Escalators and Restrooms are indicated on each floor. Elevators are conveniently located throughout the hotel for guests with disabilities or where no escalator is present.

Crossing Between Towers: Cross between towers via the Blue Level Skybridge or the Concourse on the Bronze Level. You may also cross on the Green Level via the crosswalk on Stetson Drive.
REFERENCE COMMITTEE ROOM ASSIGNMENTS
SUNDAY, JUNE 10

8:30AM – Noon
Constitution & Bylaws                      Crystal Ballroom
Reference Committee B                    Regency Ballroom B
Reference Committee C                    Regency Ballroom C
Reference Committee D                    Regency Ballroom D
Reference Committee G                    Regency Ballroom A

1:30pm- 5pm
Reference Committee A                    Regency Ballroom A
Reference Committee E                    Regency Ballroom D
Reference Committee F                    Grand Ballroom
2018 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES


The House of Delegates will convene at 2 p.m. on June 9, at the Hyatt Regency Chicago.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

<table>
<thead>
<tr>
<th>State</th>
<th>Delegate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>4</td>
</tr>
<tr>
<td>Alaska</td>
<td>1</td>
</tr>
<tr>
<td>Arizona</td>
<td>5</td>
</tr>
<tr>
<td>Arkansas</td>
<td>3</td>
</tr>
<tr>
<td>California</td>
<td>22</td>
</tr>
<tr>
<td>Colorado</td>
<td>5</td>
</tr>
<tr>
<td>Connecticut</td>
<td>4</td>
</tr>
<tr>
<td>Delaware</td>
<td>1</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>2</td>
</tr>
<tr>
<td>Florida</td>
<td>14</td>
</tr>
<tr>
<td>Georgia</td>
<td>5</td>
</tr>
<tr>
<td>Hawaii</td>
<td>2</td>
</tr>
<tr>
<td>Idaho</td>
<td>1</td>
</tr>
<tr>
<td>Illinois</td>
<td>11</td>
</tr>
<tr>
<td>Indiana</td>
<td>5</td>
</tr>
<tr>
<td>Iowa</td>
<td>3</td>
</tr>
<tr>
<td>Kansas</td>
<td>3</td>
</tr>
<tr>
<td>Kentucky</td>
<td>4</td>
</tr>
<tr>
<td>Louisiana</td>
<td>4</td>
</tr>
<tr>
<td>Maine</td>
<td>2</td>
</tr>
<tr>
<td>Maryland</td>
<td>5</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>13</td>
</tr>
<tr>
<td>Michigan</td>
<td>12</td>
</tr>
<tr>
<td>Minnesota</td>
<td>5</td>
</tr>
<tr>
<td>Mississippi</td>
<td>3</td>
</tr>
<tr>
<td>Missouri</td>
<td>5</td>
</tr>
<tr>
<td>Montana</td>
<td>1</td>
</tr>
<tr>
<td>Nebraska</td>
<td>2</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1</td>
</tr>
<tr>
<td>New Jersey</td>
<td>7</td>
</tr>
<tr>
<td>New Mexico</td>
<td>2</td>
</tr>
<tr>
<td>New York</td>
<td>19</td>
</tr>
<tr>
<td>North Carolina</td>
<td>6</td>
</tr>
<tr>
<td>North Dakota</td>
<td>1</td>
</tr>
<tr>
<td>Ohio</td>
<td>11</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>4</td>
</tr>
<tr>
<td>Oregon</td>
<td>2</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>14</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>2</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>2</td>
</tr>
<tr>
<td>South Carolina</td>
<td>5</td>
</tr>
<tr>
<td>South Dakota</td>
<td>1</td>
</tr>
<tr>
<td>Tennessee</td>
<td>5</td>
</tr>
<tr>
<td>Texas</td>
<td>18</td>
</tr>
<tr>
<td>Utah</td>
<td>2</td>
</tr>
<tr>
<td>Vermont</td>
<td>1</td>
</tr>
<tr>
<td>Virgin Islands</td>
<td>1</td>
</tr>
<tr>
<td>Virginia</td>
<td>7</td>
</tr>
<tr>
<td>Washington</td>
<td>4</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>5</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1</td>
</tr>
</tbody>
</table>

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

<table>
<thead>
<tr>
<th>Specialty Society</th>
<th>Delegate</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Academy of Child and Adolescent Psychiatry</td>
<td>2</td>
</tr>
<tr>
<td>American Academy of Dermatology</td>
<td>3</td>
</tr>
<tr>
<td>American Academy of Family Physicians</td>
<td>18</td>
</tr>
<tr>
<td>American Academy of Neurology</td>
<td>3</td>
</tr>
<tr>
<td>American Academy of Ophthalmology</td>
<td>4</td>
</tr>
<tr>
<td>American Academy of Orthopaedic Surgeons</td>
<td>7</td>
</tr>
<tr>
<td>American Academy of Otolaryngology - Head and Neck Surgery</td>
<td>3</td>
</tr>
<tr>
<td>American Academy of Pediatrics</td>
<td>9</td>
</tr>
<tr>
<td>American Academy of Physical Med. &amp; Rehabilitation</td>
<td>2</td>
</tr>
<tr>
<td>American Association of Gynecologic Laparoscopists</td>
<td>2</td>
</tr>
<tr>
<td>American College of Cardiology</td>
<td>6</td>
</tr>
<tr>
<td>American College of Chest Physicians</td>
<td>3</td>
</tr>
<tr>
<td>American College of Emergency Physicians</td>
<td>7</td>
</tr>
<tr>
<td>American College of Gastroenterology</td>
<td>2</td>
</tr>
<tr>
<td>American College of Physicians</td>
<td>23</td>
</tr>
<tr>
<td>American College of Radiology</td>
<td>7</td>
</tr>
<tr>
<td>American College of Physicians 23</td>
<td>23</td>
</tr>
<tr>
<td>American College of Radiology 7</td>
<td>7</td>
</tr>
<tr>
<td>American College of Rheumatology</td>
<td>2</td>
</tr>
<tr>
<td>American College of Surgeons</td>
<td>13</td>
</tr>
<tr>
<td>American Congress of Obstetricians and Gynecologists</td>
<td>12</td>
</tr>
<tr>
<td>American Gastroenterological Association</td>
<td>2</td>
</tr>
<tr>
<td>American Institute of Ultrasound in Medicine</td>
<td>2</td>
</tr>
<tr>
<td>American Medical Group Association</td>
<td>3</td>
</tr>
<tr>
<td>American Psychiatric Association</td>
<td>8</td>
</tr>
<tr>
<td>American Roentgen Ray Society</td>
<td>3</td>
</tr>
<tr>
<td>American Academy of Clinical Pathology</td>
<td>3</td>
</tr>
<tr>
<td>American Society for Dermatologic Surgery</td>
<td>2</td>
</tr>
<tr>
<td>American Society for Gastrointestinal Endoscopy</td>
<td>2</td>
</tr>
<tr>
<td>American Society of Anesthesiologists</td>
<td>6</td>
</tr>
<tr>
<td>American Society of Cataract and Refractive Surgery</td>
<td>2</td>
</tr>
<tr>
<td>American Society of Clinical Oncology</td>
<td>3</td>
</tr>
<tr>
<td>American Society of Echocardiography</td>
<td>2</td>
</tr>
<tr>
<td>American Society of Hematology</td>
<td>2</td>
</tr>
<tr>
<td>American Society of Plastic Surgeons</td>
<td>2</td>
</tr>
<tr>
<td>American Thoracic Society</td>
<td>2</td>
</tr>
<tr>
<td>American Urological Association</td>
<td>2</td>
</tr>
<tr>
<td>College of American Pathologists</td>
<td>3</td>
</tr>
<tr>
<td>Infectious Diseases Society of America</td>
<td>2</td>
</tr>
<tr>
<td>North American Spine Society</td>
<td>2</td>
</tr>
<tr>
<td>Radiological Society of North America</td>
<td>3</td>
</tr>
<tr>
<td>Society of Critical Care Medicine</td>
<td>2</td>
</tr>
<tr>
<td>Society of Hospital Medicine</td>
<td>2</td>
</tr>
<tr>
<td>The Endocrine Society</td>
<td>2</td>
</tr>
<tr>
<td>United States and Canadian Academy of Pathology</td>
<td>2</td>
</tr>
</tbody>
</table>

Remaining eligible national medical specialty societies (79) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, Medical Student Section, Minority Affairs Section, Organized Medical Staff Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

<table>
<thead>
<tr>
<th>Category</th>
<th>Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medical Associations</td>
<td>273</td>
</tr>
<tr>
<td>National Medical Specialty Societies</td>
<td>271</td>
</tr>
<tr>
<td>Professional Interest Medical Associations</td>
<td>2</td>
</tr>
<tr>
<td>Other National Societies (AMWA, AOA, NMA)</td>
<td>3</td>
</tr>
<tr>
<td>Medical Student Regional Delegates</td>
<td>27</td>
</tr>
<tr>
<td>Resident and Fellow Delegate Representatives</td>
<td>26</td>
</tr>
<tr>
<td>Sections</td>
<td>10</td>
</tr>
<tr>
<td>Services</td>
<td>5</td>
</tr>
<tr>
<td>Total Delegates</td>
<td>617</td>
</tr>
</tbody>
</table>

Registration facilities will be maintained at the Hyatt Regency Chicago in the Grand Ballroom Foyer.

David O. Barbe, MD, MHA  
President

Susan R. Bailey, MD  
Speaker, House of Delegates

Jesse M. Ehrenfeld, MD, MPH  
Secretary
2017-2018

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President - David O. Barbe .................................................. Mountain Grove, Missouri
President-Elect - Barbara L. McAneny ........................................... Albuquerque, New Mexico
Immediate Past President - Andrew W. Gurman .......................... Hollidaysburg, Pennsylvania
Secretary - Jesse M. Ehrenfeld .................................................. Nashville, Tennessee
Speaker, House of Delegates - Susan R. Bailey ................................. Fort Worth, Texas
Vice Speaker, House of Delegates - Bruce A. Scott ........................... Louisville, Kentucky

Willarda V. Edwards (2020) ....................................................... Baltimore, Maryland
Gerald E. Harmon, Chair (2021) ............................................ Pawleys Island, South Carolina
Patrice A. Harris (2019) .............................................................. Atlanta, Georgia
Russell W.H. Kridel (2018) .......................................................... Houston, Texas
William A. McDade (2020) ....................................................... Metairie, Louisiana
S. Bobby Makkamala (2021) ....................................................... Flint, Michigan
Stephen R. Permut (2018) ......................................................... Lewes, Delaware
Jack Resneck, Jr, Chair-Elect (2018) ........................................ San Rafael, California
Ryan J. Ribeira (2019) ............................................................... Mountain View, California
Karthik V. Sarma (2018) .............................................................. Los Angeles, California
Carl A. Sirio (2018) ................................................................. Pittsburgh, Pennsylvania
Georgia A. Tuttle (2019) ......................................................... Lebanon, New Hampshire
Kevin W. Williams (2020) ...................................................... Nashville, Tennessee

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Colette R. Willins, Chair, Westlake, Ohio (2019); Jerome C. Cohen, Vice Chair, Loch Sheldrake, New York (2021);
Naiim S. Ali, Burlington, Vermont (Resident) (2018); Patricia L. Austin, Alamo, California (2018); Madelyn E. Butler, Tampa, Florida (2018); Pino D. Colone, Howell, Michigan (2020); Cyndi J. Yag-Howard, Naples, Florida (2018); Joy Lee, Washington, District of Columbia (Student) (2018); Ex Officio, without vote: Susan R. Bailey, Fort Worth, Texas; Bruce A. Scott, MD, Louisville, Kentucky.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Dennis S. Agliano, Tampa, Florida Chair (2018); David Fleming, Columbia, Missouri (2024); Marc Mendelsohn, Brooklyn, New York (Resident) (2018); Kathryn L. Moseley, Ann Arbor, Michigan (2020); Alexander M. Rosenau, Allentown, Pennsylvania (2022); James E. Sabin, Boston, Massachusetts (2019); Laurie Schleimer, Cambridge, Massachusetts (Student) (2019); Peter A. Schwartz, Reading, Pennsylvania (2023); Monique A. Spillman, Dallas, Texas (2021).
Secretary: Eliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION
E. Scott Ferguson, West Memphis, Arkansas, Chair (2018); Jerry D. Kennett, Columbia, Missouri, Vice Chair (2018);
David H. Aizuss, Encino, California (2018); Seyed H. Atefi, Bridgeport, Connecticut (2018); Hans C. Arora, Cleveland Heights, Ohio (Resident) (2018); Mary S. Carpenter, Winner, South Dakota (2018); Christopher C. Clifford, Reno, Nevada (Student) (2018); Gary W. Floyd, Keller, Texas (2018); Linda B. Ford, Bellevue, Nebraska (AMPAC Observer) (2018); Marilyn J. Heine, Dresher, Pennsylvania (2018); Beth Irish, Bend, Oregon (Alliance Liaison) (2018); Heather A. Smith, New York, New York (2018); David T. Tayloe, Jr., Goldsboro, North Carolina (2018); Willie Underwood, III, Buffalo, New York (2018).
Secretary: George Cox, Washington, District of Columbia.
COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Glenn A. Loomis, LaGrangeville, New York, Chair (2019); Alfred Herzog, Hartford, Connecticut, Vice Chair (2019); Mary T. Herald, Summit, New Jersey (2018) James Goodyear, North Wales, Pennsylvania (2021); Shannon Pryor, Washington, District of Columbia (2020); Clarence Chou, Milwaukee, Wisconsin (2020); Edmond Cabbabe, St. Louis, Missouri (2021); Gary Thal, Northbrook, Illinois (2021); Matthew Lecuyer, Providence, Rhode Island (Resident) (2019). Katherine Marsh (Student) (2018).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Lynne M. Kirk, Dallas, Texas, Chair (2019); Carol D. Berkowitz, Torrance, California, Chair-elect (2019); Patricia L. Turner, Chicago, Illinois, Immediate Past Chair (2019); Jacqueline A. Bello, Bronx, New York, Member-at-large (2021); Robert B. Goldberg, New York, New York (2021); Arjun Gupta, East Hanover, New Jersey (Student) (2018); Cynthia A. Jumper, Lubbock, Texas (2020); Liana Puscas, Durham, North Carolina (2021); Niranjan V. Rao, New Brunswick, New Jersey (2018); Luke V. Selby, Denver, Colorado (Resident) (2020); Krystal L. Tomei, Cleveland, Ohio (2021); John P. Williams, Pittsburgh, Pennsylvania (2019).
Secretary: Carrie Radabaugh, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
Paul A. Wertsch, Madison, Wisconsin, Chair (2018); James G. Hinsdale, San Jose, California, Chair-elect (2019); Meena Davuluri, New York, New York (Resident) (2020); Lisa Egbert, Dayton, Ohio (2021); W. Alan Harmon, Jacksonville, Florida (2020); Lynn Jeffers, Camarillo, California (2020); Peter Lavine, Washington, District of Columbia (2018); Asa Lockhart, Tyler, Texas (2018); Peter S. Lund, Erie, Pennsylvania, (2018); Thomas Madejski, Medina, New York (2019); Sarah Smith, Anaheim, California (Student) (2018); Lynda M. Young, Worcester, Massachusetts (2021).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Robert A. Gilchick, Los Angeles, California, Chair (2018); Robyn F. Chatman, Cincinnati, Ohio, Chair-elect (2019); John T. Carlo, Dallas, Texas (2021); Noel N. Deep, Antigo, Wisconsin (2019); Alexander Ding, Belmont, California (2020); Kira A. Geraci-Ciardullo, Mamaroneck, New York (2018); Christina Kratschmer, Brooklyn, New York (Student) (2018); Mary LaPlante, Cleveland, Ohio (2021); Michael Lubrano, San Francisco, CA (Resident) (2020); Michael M. Miller, Madison, Wisconsin (2018); Bruce M. Smoller, Chevy Chase, Maryland (2019); David J. Welsh, Batesville, Indiana (2020).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
Vidya S. Kora, Michigan City, Indiana, Chair; Lyle S. Thorstenson, Nacogdoches, Texas, Secretary; Grayson W. Armstrong, Boston, Massachusetts (Resident); Brooke M. Buckley, Annapolis, Maryland; Steven J. Fleischman, New Haven, Connecticut; Linda B. Ford, Bellevue, Nebraska; Benjamin Z. Galper, McLean, Virginia; Dev A. GnanaDev, Colton, California; Stephen A. Imbeau, Florence, South Carolina; Ashtin Jeney, Washington, District of Columbia (Student); James L. Milani, Libertyville, Illinois; Michael Suk, Danville, Pennsylvania.
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.
EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

Lonnie R. Bristow 1995-1996
Peter W. Carmel 2011-2012
Yank D. Coble, Jr. 2002-2003
Richard F. Corlin 2001-2002
Nancy W. Dickey 1998-1999
J. Edward Hill 2005-2006
Ardis D. Hoven 2013-2014
Jeremy A. Lazarus 2012-2013
Nancy W. Dickey 1998-1999
J. Edward Hill 2005-2006
Ardis D. Hoven 2013-2014

FORMER TRUSTEES

Herman I. Abromowitz 1997-2005
Susan Hershberg Adelman 1998-2002
Kendall S. Allred 2008-2009
Raj S. Ambay 2009-2011
Joseph P. Annis 2006-2014
John H. Armstrong 2002-2006
Maya A. Babu 2013-2017
Timothy E. Baldwin 1987-1989
Regina M. Benjamin 1995-1998
Scott L. Bernstein 1991-1992
Stefano M. Bertozzi 1986-1988
David J. Brailer 1985-1986
Lonnie R. Bristow 1985-1994
Duane M. Cady 1999-2007
Peter Carmel 2002-2010
Alice A. Chenault 1984-1985
Yank D. Coble 1994-2001
David S. Cockrum 1993-1994
MaryAnn Contogiannis 1989-1993
Malini Daniel 2012-2013
Christopher M. DeRienzo 2006-2008
Nancy W. Dickey 1989-1997
Alexander Ding 2011-2013
Timothy T. Flaherty 1994-2003
Palma E. Formica 1990-1999
Melissa J. Garretson 1992-1993
Michael S. Goldrich 1993-1997
Julie K. Goonewardene 2012-2016
Alan C. Hartford 1989-1990
Cyrim M. Hetsko 2003-2011
Joseph M. Heyman 2002-2010
J. Edward Hill 1996-2004
Ardis D. Hoven 2005-2012
Hillary D. Johnson 2001-2002
Christopher K. Kay 2008-2012
Edward L. Langston 2003-2011
Matthew C. Lawyer 2004-2005
Jeremy A. Lazarus 2005-2011
D. Ted Lewers 1993-2002

W. J. Lewis 1979-1984
Audrey J. Ludwig 1990-1991
Justin B. Mahida 2009-2010
Omar Z. Maniya 2016-2017
Robert R. McMillan 2002-2008
Sandeept “Sunny” Mistry 2000-2001
Donald J. Palmisano 1996-2002
Rebecca J. Patchin 1988-1989
Rebecca J. Patchin 2003-2011
Pamela Petersen-Craig 1996-1998
Dina Marie Pitta 2015-2016
William G. Pleased, III 1998-2005
Stephen Pool 1995-1996
Liana Puscas 1999-2001
Thomas R. Reardon 1990-1998
Kevin C. Reilly 2003-2005
Ryan J. Ribeira 2013-2014
Joseph A. Riggs 1999-2003
J. James Rohack 2001-2008
David A. Rosman 2002-2004
Samantha L. Rosman 2005-2009
Raymond Scalettar 1985-1994
Bruce A. Scott 1998-2002
Randolph D. Smoak, Jr. 1992-1999
Steven J. Stack 2006-2014
Lowell H. Steen 1975-1982
Michael Suk 1994-1995
Andrew M. Thomas 1997-1999
Jeffrey A. Towson 1998-1999
Jordan M. VanLare 2011-2012
Robert M. Wah 2005-2013
Peter Y. Watson 2001-2003
Monica C. Wemy 2011-2013
Meredith C. Williams 2010-2011
Cecil B. Wilson 2002-2009
Percy Wootton 1991-1996
SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

(The following are not members of the House of Delegates, but are representatives of the following societies which are represented in the SSS.)

American Academy of Emergency Medicine ................................................. Joseph Wood, MD, JD
American Society of Nuclear Cardiology ....................................................... Saurabh Malhotra, MD
Society of Gynecologic Oncologists ............................................................... Carol Brown, MD
National Lipid Association ......................................................................... Michael Davidson, MD
Society of Cardiovascular Computed Tomography ...................................... Dustin Thomas, MD
Korean American Medical Association ......................................................... John Yun, MD
Association of Professors of Dermatology ................................................... Christopher R. Shea, MD
American Society for Reconstructive Microsurgery ..................................... Gregory R. D. Evans, MD
American Rhinologic Society ...................................................................... Kevin McCains, MD
North American Neuromodulation Society ............................................... Haroon Hameed, MD
North American Neuro-Ophthalmology Society ......................................... Thomas Mizen, MD
American Association of Endocrine Surgeons ............................................ Steven De Jong, MD
American College of Medical Toxicology .................................................. Charles McKay, MD
Association of Academic Physiatrists .......................................................... Samuel Chu, MD
American Association of Hip and Knee Surgeons ....................................... Edward Tanner, MD
American Society of Neuroimaging ............................................................. Ryan Hakimi, MD
American College of Correctional Physicians ............................................ Charles Lee, MD
American Epilepsy Society .......................................................................... David M. Labiner, MD
Americas Hernia Society ............................................................................ J. Scott Roth, MD
American Society of Regional Anesthesia and Pain Medicine .................. Asokumar Buvanendran, MD
American Contact Dermatitis Society ......................................................... Bruce Brod, MD
American Academy of Sleep Medicine ....................................................... Alejandro Chediak, MD
American Society of Cytopathology ............................................................ Swati Mehrotra, MD
MEMBERS OF THE HOUSE OF DELEGATES - JUNE 2018
The following is a list of delegates and alternate delegates to the House of Delegates
as reported to the Executive Vice President

<table>
<thead>
<tr>
<th>Medical Association of the State of Alabama</th>
<th>Arkansas Medical Society</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delegate(s)</strong></td>
<td><strong>Delegate(s)</strong></td>
</tr>
<tr>
<td>Jorge Alsip, Daphne AL</td>
<td>E Scott Ferguson, West Memphis AR</td>
</tr>
<tr>
<td>Steven P. Furr, Jackson AL</td>
<td>Alan Wilson, Crossett AR</td>
</tr>
<tr>
<td>B Jerry Harrison, Haleyville AL</td>
<td><strong>Alternate Delegate(s)</strong></td>
</tr>
<tr>
<td>George C. Smith, Jr, Lineville AL</td>
<td>Omar Atiq, Little Rock AR</td>
</tr>
<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td>Amy Cahill, Pine Bluff AR</td>
</tr>
<tr>
<td>Raymond Broughton, Theodore AL</td>
<td>Eugene Shelby, Hot Springs AR</td>
</tr>
<tr>
<td>Mark Haygood, Mobile AL</td>
<td><strong>Regional Medical Student Delegate(s)</strong></td>
</tr>
<tr>
<td>Harry Kuberg, Russellville AL</td>
<td>Hannah M Ficarino, Mobile AL</td>
</tr>
<tr>
<td>William Schneider, Huntsville AL</td>
<td><strong>Regional Medical Student Alternate Delegate(s)</strong></td>
</tr>
<tr>
<td><strong>Regional Medical Student Delegate(s)</strong></td>
<td>Sanjay Menghani, Vineland NJ</td>
</tr>
<tr>
<td>Hannah M Ficarino, Mobile AL</td>
<td><strong>Regional Medical Student Alternate Delegate(s)</strong></td>
</tr>
<tr>
<td><strong>Arkansas Medical Society</strong></td>
<td>Sanjay Menghani, Vineland NJ</td>
</tr>
<tr>
<td><strong>Delegate(s)</strong></td>
<td><strong>Delegate(s)</strong></td>
</tr>
<tr>
<td>G. Edward Bryant, West Memphis AR</td>
<td><strong>Delegate(s)</strong></td>
</tr>
<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td><strong>Alternate Delegate(s)</strong></td>
</tr>
<tr>
<td><strong>Regional Medical Student Delegate(s)</strong></td>
<td><strong>Regional Medical Student Alternate Delegate(s)</strong></td>
</tr>
<tr>
<td><strong>Alaska State Medical Association</strong></td>
<td><strong>Regional Medical Student Alternate Delegate(s)</strong></td>
</tr>
<tr>
<td><strong>Delegate(s)</strong></td>
<td>Sanjay Menghani, Vineland NJ</td>
</tr>
<tr>
<td>Alex Malter, Juneau AK</td>
<td><strong>Arkansas Medical Society</strong></td>
</tr>
<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td><strong>Delegate(s)</strong></td>
</tr>
<tr>
<td>Mary Ann Foland, Anchorage AK</td>
<td>E Scott Ferguson, West Memphis AR</td>
</tr>
<tr>
<td><strong>Regional Medical Student Delegate(s)</strong></td>
<td>Alan Wilson, Crossett AR</td>
</tr>
<tr>
<td><strong>Arkansas Medical Society</strong></td>
<td><strong>Alternate Delegate(s)</strong></td>
</tr>
<tr>
<td><strong>Delegate(s)</strong></td>
<td>Omar Atiq, Little Rock AR</td>
</tr>
<tr>
<td><strong>Alternate Delegate(s)</strong></td>
<td>Amy Cahill, Pine Bluff AR</td>
</tr>
<tr>
<td><strong>Regional Medical Student Delegate(s)</strong></td>
<td>Eugene Shelby, Hot Springs AR</td>
</tr>
<tr>
<td><strong>Regional Medical Student Alternate Delegate(s)</strong></td>
<td><strong>Regional Medical Student Alternate Delegate(s)</strong></td>
</tr>
<tr>
<td><strong>Arkansas Medical Society</strong></td>
<td>Sanjay Menghani, Vineland NJ</td>
</tr>
</tbody>
</table>

This list does not reflect temporary changes for this meeting.
California Medical Association

Alternate Delegate(s)
  Dev A. GnanaDev, Colton CA
  Samuel Huang, Los Angeles CA
  Scott Richard Karlan, West Hollywood CA
  Nikan Khatibi, Laguna Niguel CA
  Mark H. Kogan, San Pablo CA
  Sandra Mendez, Sacramento CA
  Chang Na, Bakersfield CA
  Abhinaya Narayanan, Los Angeles CA
  Richard Pan, Sacramento CA
  Mihir Parikh, La Jolla CA
  Timothy G Parker, Jr, San Diego CA
  Sion Roy, Torrance CA
  Holly Yang, San Diego CA
  Marcy Zwelling-Aamot, Los Alamitos CA

Resident and Fellow Sectional Delegate(s)
  Hunter Pattison, Sacramento CA

Resident and Fellow Sectional Alternate Delegate(s)
  Jacob Burns, Sacramento CA

Regional Medical Student Delegate(s)
  Rachel Ekaireb, San Francisco CA

Regional Medical Student Alternate Delegate(s)
  Cecilia Leggett, San Diego CA
  Neil Rens, Stanford CA

Colorado Medical Society

Delegate(s)
  David Downs, Denver CO
  Jan Kief, Highlands Ranch CO
  A. "Lee" Morgan, Denver CO
  Tamaan Osbourne-Roberts, Denver CO
  Lynn Parry, Littleton CO

Alternate Delegate(s)
  Carolynn Francavilla, Lakewood CO
  Rachelle M. Klammer, Denver CO
  Katie Lozano, Centennial CO
  Brigitta J. Robinson, Centennial CO
  Michael Volz, Englewood CO

Resident and Fellow Sectional Delegate(s)
  Luke V. Selby, Denver CO

Regional Medical Student Delegate(s)
  Adam Panzer, Forest Hills NY

Regional Medical Student Alternate Delegate(s)
  Halea K Meese, Denver CO

Connecticut State Medical Society

Delegate(s)
  Seyed H. Aleali, Bridgeport CT
  Michael M. Deren, New London CT
  Alfred Herzog, Hartford CT
  Theodore Zanker, Cheshire CT

Alternate Delegate(s)
  Michael L. Carius, Stratford CT
  Katherine L. Harvey, Torrington CT
  Bollepalli Subbarao, Middletown CT
  Steven C. Thomquist, Bethany CT

Regional Medical Student Delegate(s)
  Devin Bageac, Farmington CT

Regional Medical Student Alternate Delegate(s)
  Kathryn Topalis, Simsbury CT

Medical Society of Delaware

Delegate(s)
  Kelly S. Eschbach, Wilmington DE

Alternate Delegate(s)
  Janice Tildon-Burton, Wilmington DE

Regional Medical Student Delegate(s)
  Stephanie Howe Guarino, Wilmington DE

Medical Society of the District of Columbia

Delegate(s)
  Joseph E. Gutierrez, McLean VA
  Peter E. Lavine, Washington DC

Alternate Delegate(s)
  Barry L. Lewis, Washington DC
  J Desiree Pineda, Washington DC
  Raymond K. Tu, Washington DC

Regional Medical Student Alternate Delegate(s)
  Damani McIntosh-Clarke, Arlington VA

This list does not reflect temporary changes for this meeting.
Florida Medical Association

Delegate(s)

- Madelyn E. Butler, Tampa FL
- Ronald Frederic Giffler, Fort Lauderdale FL
- Walter Alan. Harmon, Jacksonville FL
- Corey L. Howard, Naples FL
- E Coy Irvin, Jr, Pensacola FL
- Trachella Johnson Foy, Jacksonville FL
- John Montgomery, Fleming Island FL
- Ralph Jacinto Nobo, Jr, Bartow FL
- Arthur E. Palamara, Hollywood FL
- Michael L. Patete, Venice FL
- Alan B. Pillersdorf, Lake Worth FL
- Aaron Sudbury, Bradenton FL
- Hansel Tookes, III, Miami FL
- Michael Zimmer, St Petersburg FL

Alternate Delegate(s)

- Jose F. Arrascue, Atlantis FL
- Ankush Bansal, West Palm Beach FL
- James Booker, Winter Haven FL
- Andrew Cooke, Orlando FL
- Aaron Elkin, Miami FL
- James Nathan Goldenberg, Atlantis FL
- Rebecca Lynn Johnson, Tampa FL
- Mark E. Panna, Jr, Gainesville FL
- Jason J. Pirozzolo, Winter Garden FL
- Sergio B. Seoane, Barton FL
- James St George, Ponte Verdra FL

Resident and Fellow Sectional Alternate Delegate(s)

- Michelle Falcone, Miami FL

Regional Medical Student Delegate(s)

- Jessica Walsh O’Sullivan, Orlando FL

Regional Medical Student Alternate Delegate(s)

- Charlotte K George, Tallahassee FL
- Tanya Singh, Orlando FL

Medical Association of Georgia

Delegate(s)

- S William Clark, III, Waycross GA
- Michael E. Greene, Macon GA
- Billie Luke Jackson, Macon GA
- Joy A. Maxey, Atlanta GA
- Sandra B. Reed, Atlanta GA

Alternate Delegate(s)

- John S. Antalis, Dalton GA
- Jack Chapman, Gainesville GA
- John Goldman, Atlanta GA
- Frank McDonald, Gainesville GA
- Ali Rahimi, Atlanta GA
- Gary Richter, Atlanta GA

Resident and Fellow Sectional Alternate Delegate(s)

- Kunj Patel, Atlanta GA

Hawaii Medical Association

Delegate(s)

- Jone Geimer-Flanders, Honolulu HI
- Roger Kimura, Honolulu HI

Alternate Delegate(s)

- Christopher Flanders, Honolulu HI

Idaho Medical Association

Delegate(s)

- A. Patrice Burgess, Boise ID

Alternate Delegate(s)

- Keith Davis, Shoshone ID
- William Woodhouse, Pocatello ID

Illinois State Medical Society

Delegate(s)

- Aadil Ahmed, Maywood IL
- Thomas M. Anderson, Jr, Chicago IL
- Craig Alvin Backs, Springfield IL
- James Bull, Silvis IL
- Howard Chodash, Springfield IL
- Peter E. Eupierre, Melrose Park IL
- Richard A. Geline, Glenview IL
- Steve Malkin, Arlington Heights IL
- James L. Milam, Libertyville IL
- Nestor Ramirez-Lopez, Champaign IL
- Shastri Swaminathan, Chicago IL

Alternate Delegate(s)

- Rodney Alford, Watseka IL
- Howard Axe, Arlington Heights IL

This list does not reflect temporary changes for this meeting.
Illinois State Medical Society

Alternate Delegate(s)
Christine Bishof, Forest Park IL
Scott A. Cooper, Chicago IL
Farhad Ghamsari, Chicago IL
Lynne E. Nowak, Belleville IL
Robert Panton, Elmwood Park IL
Vikram B. Patel, South Barrington IL
Laura Shea, Springfield IL
Katherine Tynus, Chicago IL
Piyush Vyas, Lake Forest IL

Resident and Fellow Sectional Alternate Delegate(s)
Marla Rejbi, Chicago IL

Regional Medical Student Delegate(s)
Ajeet Singh, Forest Park IL

Regional Medical Student Alternate Delegate(s)
Ian Magruder, Wilmette IL

Indiana State Medical Association

Delegate(s)
Michael Hoover, Evansville IN
Vidya S. Kora, Michigan City IN
William Mohr, Kokomo IN
Stephen Tharp, Frankfort IN
David Welsh, Batesville IN

Alternate Delegate(s)
Deepak Azad, Floyds Knobs IN
Heidi Dunnaway, Indianapolis IN
Brent Mohr, South Bend IN
Rhonda Sharp, Lagrange IN
Thomas Vodic, Elkhart IN

Resident and Fellow Sectional Delegate(s)
Kimberly Swartz, Indianapolis IN

Regional Medical Student Alternate Delegate(s)
Arvind Haran, Indianapolis IN
Giovanni Rodriguez, Indianapolis IN

Iowa Medical Society

Delegate(s)
Michael Kitchell, Ames IA
Robert Lee, Johnston IA
Victoria Sharp, Iowa City IA

Alternate Delegate(s)
Jeffrey Anderson, Johnston IA
Michael A. Romano, Omaha NE
Joyce Vista-Wayne, Des Moines IA

Resident and Fellow Sectional Alternate Delegate(s)
Daniel Terveen, Iowa City IA

Kansas Medical Society

Delegate(s)
Terry L. Poling, Wichita KS
Arthur D. Snow, Jr, Shawnee Mission KS
Richard B. Warner, Shawnee Mission KS

Alternate Delegate(s)
Jennifer Bacani-McKenney, Fredonia KS
Robert Gibbs, Parsons KS
James H. Gilbaugh, Wichita KS

Kentucky Medical Association

Delegate(s)
David J. Bensema, Lexington KY
J Gregory Cooper, Cynthiana KY
Bruce A. Scott, Louisville KY
Donald J. Swikert, Edgewood KY

Alternate Delegate(s)
Robert Couch, Louisville KY
Shawn C. Jones, Paducah KY
William B. Monnig, Crestview Hills KY
Robert A. Zaring, Louisville KY

Louisiana State Medical Society

Delegate(s)
Luis M. Alvarado, Mandeville LA
Floyd Anthony Buras, Jr, Metairie LA
Dolleen Mary Licciardi, Jefferson LA
Lee Stevens, Shreveport LA

Alternate Delegate(s)
Susan M. Bankston, Baton Rouge LA
William Clark, Baton Rouge LA
Myo Myint, New Orleans LA
Rachel Spann, New Orleans LA

Regional Medical Student Delegate(s)
Neal Dixit, New Orleans LA

This list does not reflect temporary changes for this meeting.
Maine Medical Association
Delegate(s)
Richard A. Evans, Dover Foxcroft ME
Maroulla S. Gleaton, Augusta ME
Alternate Delegate(s)
Robert Schlager, Pittsfield ME

MedChi: The Maryland State Medical Society
Delegate(s)
Habhaajan Singh Ajrawat, Potomac MD
George H. A. Bone, Largo MD
Shannon Pryor, Chevy Chase MD
Stephen J. Rockower, Rockville MD
Bruce M. Smoller, Chevy Chase MD
Alternate Delegate(s)
Brooke M. Buckley, Annapolis MD
Loralie Dawn Ma, Fulton MD
Lucy Nam, Baltimore MD
Gary Pushkin, Baltimore MD
Padmini Ranasinghe, Baltimore MD

Regional Medical Student Delegate(s)
Pauline P. Huynh, Baltimore MD

Massachusetts Medical Society
Delegate(s)
Maryanne C. Bombaugh, Falmouth MA
Theodore A. Calianos, II, Mashpee MA
Alain A. Chaoui, Boxford MA
Alice Coombs-Tolbert, Richmond VA
Ronald Dunlap, Norwell MA
McKinley Glover, Boston MA
Francis P. Mac Millan, Jr, North Andover MA
Mario E. Motta, Salem MA
Lee S. Perrin, Southborough MA
Richard Pieters, Jr, Duxbury MA
David A. Rosman, Jamaica Plain MA
Thomas E. Sullivan, Beverly MA
Lynda M. Young, Worcester MA
Alternate Delegate(s)
Carole Allen, Arlington MA
Nicolas Argy, Dover MA
Dennis Dimitri, Worcester MA
Henry Dorkin, Auburndale MA
Melody J. Eckardt, Milton MA
Christopher Garofalo, N Attleboro MA

Massachusetts Medical Society
Alternate Delegate(s)
Kathryn Hughes, North Andover MA
Lynda G. Kabbash, Chestnut Hill MA
Akshay Kapoor, Worcester MA
Matthew Lecuyer, Providence RI
Michael Medlock, Lexington MA
Kenath Shamir, Fall River MA
Spiro Spanakis, Shrewsbury MA
Ellana Stinson, Quincy MA

Resident and Fellow Sectional Delegate(s)
Mark Kashtan, Boston MA

Resident and Fellow Sectional Alternate Delegate(s)
Carl Streed, Jr, Boston MA

Regional Medical Student Delegate(s)
Danny Vazquez, Jr, Boston MA

Regional Medical Student Alternate Delegate(s)
Rohan Rastogi, Boston MA
Andrew Vallejo, Boston MA

Michigan State Medical Society
Delegate(s)
Michael D. Chafty, Kalamazoo MI
Betty S. Chu, Bloomfield Hills MI
Pino D. Colone, Howell MI
Sarah A Gorgis, Sterling Heights MI
James D. Grant, Bloomfield Hills MI
Mark C. Komorowski, Bay City MI
Alan M. Mindlin, Bloomfield Hills MI
Bassam H. Nasr, Port Huron MI
Michael A. Sandler, West Bloomfield MI
Krishna K. Sawhney, Bloomfield Hills MI
Richard E. Smith, Detroit MI
David T. Walsworth, East Lansing MI

Alternate Delegate(s)
Mohammed A. Arsiwala, Livonia MI
Paul D. Bozyk, Canton MI
Kaitlyn Dobesh, Grosse Pointe MI
Cheryl Gibson-Fountain, Grosse Pointe MI
Rose M. Ramirez, Belmont MI
Venkat K. Rao, Flint MI

Regional Medical Student Delegate(s)
Nonie Arora, Ann Arbor MI

This list does not reflect temporary changes for this meeting.
Minnesota Medical Association

Delegate(s)
John Abenstei, Oronoco MN
David L. Estrin, Plymouth MN
David D. Luehr, Barnum MN
Paul C. Matson, Mankato MN
Cindy F. Smith, Willmar MN

Alternate Delegate(s)
Andrea Hillerud, Saint Paul MN
Kathryn Lombardo, Rochester MN
William Nicholson, White Bear Lake MN
George Schoephoerster, Saint Cloud MN
David Thorson, Mahtomedi MN

Resident and Fellow Sectional Alternate Delegate(s)
Courtney Moors, Rochester MN

Mississippi State Medical Association

Delegate(s)
Claude D. Brunson, Ridgeland MS
Jennifer Bryan, Flowood MS
J Clay Hays, Jr, Jackson MS

Alternate Delegate(s)
Sharon Douglas, Madison MS
Daniel P. Edney, Vicksburg MS
Lee Voulters, Gulfport MS

Regional Medical Student Delegate(s)
William Ross, Flowood MS

Missouri State Medical Association

Delegate(s)
Elie Azrak, Saint Louis MO
Edmond Cabbabe, St Louis MO
James Conant, St. Joseph MO
Rebecca Hierholzer, Leawood KS
Warren Lovinger, Nevada MO

Alternate Delegate(s)
Joseph A. Corrado, Mexico MO
Charles W. Van Way, Fairway KS

Regional Medical Student Alternate Delegate(s)
Manna M Varghese, Kansas City MO

Montana Medical Association

Delegate(s)
Carter E. Beck, Missoula MT

Alternate Delegate(s)
Nicole C. Clark, Helena MT

Nebraska Medical Association

Delegate(s)
Kelly J. Caverzagie, Omaha NE
Kevin D. Nohner, Omaha NE

Alternate Delegate(s)
Robert Rhodes, Lincoln NE
Jordan Warchol, Arlington VA

Regional Medical Student Delegate(s)
Michael Visenio, Boston MA

Nevada State Medical Association

Delegate(s)
Wayne C. Hardwick, Reno NV
Florence Jameson, Las Vegas NV

Alternate Delegate(s)
Joseph A. Adashek, Las Vegas NV
Peter R. Fenwick, Reno NV

New Hampshire Medical Society

Delegate(s)
William J. Kassler, Bedford NH

Alternate Delegate(s)
P. Travis Harker, Manchester NH
Leonard Korn, Portsmouth NH

Medical Society of New Jersey

Delegate(s)
Donald J. Cinotti, Jersey City NJ
Joseph P. Costabile, Marlton NJ
Joseph J. Fallon, Jr, Woodbury NJ
Charles Michael Moss, Ramsey NJ
John W. Poole, Ridgewood NJ
Niranjan V. Rao, New Brunswick NJ
David Swee, Piscataway NJ

Alternate Delegate(s)
Mary Campagnolo, Bordentown NJ
Donald M. Chervenak, Florham Park NJ
Christopher Gribbin, Princeton NJ
Nancy L. Mueller, Englewood Cliffs NJ

This list does not reflect temporary changes for this meeting.
Medical Society of New Jersey

Alternate Delegate(s)
Soumen Samaddar, Pennington NJ
Steven P. Shikiar, Englewood NJ
Rocco Tutela, Jr, Highland Park NJ

Regional Medical Student Delegate(s)
Fatima Mirza, New Haven CT
Aakash Sheth, East Brunswick NJ

Regional Medical Student Alternate Delegate(s)
Priya Sushvet Kantesaria, Somerset NJ

New Mexico Medical Society

Delegate(s)
Steven Kanig, Albuquerque NM
Stephen P. Lucero, Santa Fe NM

Alternate Delegate(s)
William G. Liakos, Roswell NM
William Ritchie, Albuquerque NM

Medical Society of the State of New York

Delegate(s)
Joshua M. Cohen, New York NY
Jerome C. Cohen, Loch Sheldrake NY
Frank G. Dowling, Islandia NY
Kira Geraci-Ciardullo, Harrison NY
Robert B. Goldberg, Morristown NJ
Howard Huang, Watertown NY
Robert J. Hughes, Queensbury NY
John J. Kennedy, Schenectady NY
Andrew Y. Kleinman, Rye Brook NY
Daniel J. Koretz, Ontario NY
Bonnie L. Litvack, Mont Kisco NY
Thomas J. Madejski, Medina NY
Joseph R. Maldonado, Westernville NY
Leah S. Mc Cormack, Middletown NJ
Gregory L. Pinto, Saratoga Springs NY
Malcolm D. Reid, New York NY
Charles Rothberg, Patchogue NY
Joseph Sellers, Cobleskill NY
Corliss Varnum, Oswego NY

Alternate Delegate(s)
Mark Adams, Fairport NY
Rose Berkun, Buffalo NY
Breyen Coffin, Bronx NY

Medical Society of the State of New York

Alternate Delegate(s)
Robert A. Frankel, Brooklyn NY
David Jakubowicz, Bronx NY
Parag Mehta, Brooklyn NY
John A. Ostuni, Freeport NY
Barry Rabin, Syracuse NY
Abdul Rehman, Staten Island NY
Daniel M. Young, Windsor NY

Resident and Fellow Sectional Delegate(s)
Raymond Lorenzoni, New York NY

Resident and Fellow Sectional Alternate Delegate(s)
Jessica Cho, Brooklyn NY

Regional Medical Student Delegate(s)
Usman Aslam, Glen Cove NY
Ali Bokhari, Brooklyn NY

Regional Medical Student Alternate Delegate(s)
Michael Healey, Rochester NY
Rishi Thaker, Middletown NY

North Carolina Medical Society

Delegate(s)
William E. Bowman, Greensboro NC
Mary Ann Contogiannis, Greensboro NC
John A. Fagg, Winston-Salem NC
John R. Mangum, Sanford NC
Darlyne Menscer, Charlotte NC
Charles F. Willson, Greenville NC

Alternate Delegate(s)
Timothy M. Beittel, Fayetteville NC
G Hadley Callaway, Raleigh NC
Liana Puscas, Durham NC

Resident and Fellow Sectional Delegate(s)
Jason Hall, Durham NC

Resident and Fellow Sectional Alternate Delegate(s)
Ankit Agarwal, Chapel Hill NC

Regional Medical Student Delegate(s)
Lauren Benning, Littington NC

Regional Medical Student Alternate Delegate(s)
Lauren Edgar, Winston-Salem NC

This list does not reflect temporary changes for this meeting.
North Carolina Medical Society

Regional Medical Student Alternate Delegate(s)
  Elyse Whithorn, Fayetteville NC

North Dakota Medical Association

Delegate(s)
  Shari L. Orser, Bismarck ND
Alternate Delegate(s)
  A. Michael Booth, Bismarck ND

Ohio State Medical Association

Delegate(s)
  Anthony Armstrong, Sylvania OH
  Tyler J. Campbell, Winchester OH
  Robyn F. Chatman, Cincinnati OH
  Louito C. Edje, Toledo OH
  Lisa B. Egbert, Kettering OH
  Richard R. Ellison, Fairlawn OH
  Charles J. Hickey, Dublin OH
  Gary R. Katz, Dublin OH
  Alisha Reiss, Gettysburg OH
  William C. Sternfeld, Toledo OH
  Donna A. Woodson, Toledo OH
Alternate Delegate(s)
  Evangeline Andarsio, Kettering OH
  Brett Coldiron, Columbus OH
  Shawn Cuevas, Columbus OH
  Deepak Kumar, Dayton OH
  Julie Lin, Rootstown OH
  Carl S. Wehri, Delphos OH
  Regina Whitfield-Kekessi, West Chester OH

Resident and Fellow Sectional Delegate(s)
  Christopher Wee, Cleveland OH

Regional Medical Student Delegate(s)
  Katherine Chen, Toledo OH
  Hari Iyer, Rootstown OH

Regional Medical Student Alternate Delegate(s)
  Paige Anderson, Vermilion OH

Oklahoma State Medical Association

Delegate(s)
  Jay A. Gregory, Muskogee OK
  Bruce Storms, Chickasha OK

Alternate Delegate(s)
  Peter Aran, Tulsa OK
  Jenny Boyer, Tulsa OK
  Jean Hausheer, Lawton OK
  Woody Jenkins, Stillwater OK
  Kevin Taubman, Tulsa OK

Resident and Fellow Sectional Delegate(s)
  Eudy Bosley, Broken Arrow OK

Regional Medical Student Delegate(s)
  Chelsea McKenzie, Tulsa OK

Regional Medical Student Alternate Delegate(s)
  Mayra Salazar-Valdivia, Tulsa OK

Oregon Medical Association

Delegate(s)
  Robert Dannenhoffer, Roseburg OR
  Sylvia Ann Emory, Eugene OR

Alternate Delegate(s)
  Peter A. Bernardo, Salem OR
  Kevin Reavis, Portland OR

Pennsylvania Medical Society

Delegate(s)
  Theodore A. Christopher, Maple Glen PA
  Michael A. DellaVecchia, Berwyn PA
  James A. Goodyear, North Wales PA
  Virginia E. Hall, Hummelstown PA
  Marilyn J. Heine, Dresher PA
  Daniel B. Kimball, Jr, Wyomissing PA
  Peter S. Lund, Fairview PA
  Anthony M. Padula, Philadelphia PA
  Judith R. Pryblick, Allentown PA
  Ralph Schmeltz, Pittsburgh PA
  Scott E. Shapiro, Lower Gwynedd PA
  John W. Spurlock, Bethlehem PA
  Martin D. Trichtinger, Hatboro PA
  John P. Williams, Gibsonia PA

Alternate Delegate(s)
  Erick Bergquist, Latrobe PA
  Mark Friedlander, Nabeth PA

This list does not reflect temporary changes for this meeting.
Pennsylvania Medical Society

Alternate Delegate(s)
Kevin Owen Garrett, Allison Park PA
Aaron E. George, Chambersburg PA
Bruce A. Mac Leod, Pittsburgh PA
Jill M. Owens, Bradford PA
Evan Pollack, Bryn Mawr PA
Dane Scantling, Philadelphia PA
Rachel Thomas, Philadelphia PA
John Trickett, Jr, Scranton PA
John Michael Vasudevan, Philadelphia PA

Resident and Fellow Sectional Delegate(s)
Raghuveer Puttagunta, Danville PA

Puerto Rico Medical Association

Delegate(s)
Gonzalo V. Gonzalez-Liboy, Carolina PR
Rafael Rodriguez-Mercado, San Juan PR

Alternate Delegate(s)
Feliberti Rafael Fernandez, Guaynabo PR
Jose Luis Romany Rodriguez, San Juan PR

Rhode Island Medical Society

Delegate(s)
Alyn L. Adrain, Providence RI
Peter A. Hollmann, Cranston RI

Alternate Delegate(s)
Bradley Collins, Providence RI
Sarah Fessler, Riverside RI

South Carolina Medical Association

Delegate(s)
Gary A. Delaney, Orangeburg SC
Richard Osman, Myrtle Beach SC

This list does not reflect temporary changes for this meeting.
Texas Medical Association

Delegate(s)
Gary Floyd, Keller TX
John T. Gill, Dallas TX
Robert T. Gunby, Jr, Dallas TX
David N. Henkes, San Antonio TX
Asa C. Lockhart, Tyler TX
Kenneth L. Mattox, Houston TX
Kevin H. McKinney, Galveston TX
Larry E. Reaves, Fort Worth TX
Leslie H. Secrest, Dallas TX
Jayesh Shah, San Antonio TX
Lyle S. Thorstenson, Nacogdoches TX
E. Linda Villarreal, Edinburg TX

Alternate Delegate(s)
Gerald Ray Callas, Beaumont TX
John T. Carlo, Dallas TX
Robert H. Emmick, Jr, Austin TX
John G. Flores, Little Elm TX
Gregory M. Fuller, Keller TX
William S. Gilmer, Houston TX
Steven R. Hays, Dallas TX
Jessie Ho, Plano TX
Cynthia Jumper, Lubbock TX
Jennifer Rushton, Austin TX
Habeeb Salameh, Galveston TX
Elizabeth Torres, Sugar Land TX
Roxanne Tyroch, El Pasco TX
Arlo F. Weltge, Bellaire TX
Sherif Z. Zaafran, Houston TX

Resident and Fellow Sectional Alternate Delegate(s)
Michael Metzner, San Antonio TX

Regional Medical Student Delegate(s)
Luis Seija, Temple TX

Regional Medical Student Alternate Delegate(s)
Sinan Ali Bana, Sugar Land TX
Robert Kotaki, McAllen TX
Aaron J Wolbrueck, Fort Worth TX

Utah Medical Association

Delegate(s)
Bryce Dee Allred, Holladay UT
Mark Bair, Highland UT

Alternate Delegate(s)
Kerry Fisher, Salt Lake City UT
Richard Labasky, Sandy UT

Vermont Medical Society

Delegate(s)
Robert Block, Bennington VT

Alternate Delegate(s)
Norman Ward, Burlington VT

Medical Society of Virginia

Delegate(s)
Claudette E. Dalton, Earlysville VA
David A. Ellington, Lexington VA
Randolph J. Gould, Norfolk VA
Edward G. Koch, McLean VA
Hazle S. Konerding, Richmond VA
Mitchell B. Miller, Virginia Beach VA
Lawrence K. Monahan, Roanoke VA

Alternate Delegate(s)
Joel Thomas Bundy, Norfolk VA
Clifford L. Deal, III, Henrico VA
Kurtis Elward, Charlottesville VA
Thomas W. Eppes, Jr, Forest VA
Bhushan H. Pandya, Danville VA
Sterling N. Ransone, Jr, Deltaville VA
William Reha, Woodridge VA
Cynthia C. Romero, Virginia Beach VA

Regional Medical Student Delegate(s)
Ryan Schlobach, Norfolk VA

Regional Medical Student Alternate Delegate(s)
Abby Winn, Roanoke VA

Washington State Medical Association

Delegate(s)
Erin Harnish, Longview WA
L Elizabeth Peterson, Spokane WA
Sheila D. Rege, Pasco WA
Rodney Trytko, Spokane WA

Alternate Delegate(s)
Matthew Grierson, Bothell WA
Nariman Heshmati, Mukliteo WA
Shane Macaulay, Kirkland WA

This list does not reflect temporary changes for this meeting.
Washington State Medical Association

Alternate Delegate(s)
  Donna Smith, Seattle WA

Resident and Fellow Sectional Alternate Delegate(s)
  Colin Murphy, Seattle WA

West Virginia State Medical Association

Delegate(s)
  Constantino Y. Amores, Charleston WV
  Joseph Barry Selby, Morgantown WV

Alternate Delegate(s)
  Hoyt Burdick, Huntington WV
  James D. Felsen, Great Cacapon WV
  Bradley Henry, Charleston WV

Wisconsin Medical Society

Delegate(s)
  George Melvin Lange, Milwaukee WI
  Michael M. Miller, Oconomowoc WI
  Charles J. Rainey, River Hills WI
  Paul A. Wertsch, Madison WI
  Tosha Wetterneck, Madison WI

Alternate Delegate(s)
  Nameeta Dookeran, Pawaukee WI
  Barbara Hummel, Milwaukee WI
  Don Lee, Franklin WI
  Timothy G. Mc Avoy, Waukesha WI
  Keshni Ramnanan, Summit WI

Resident and Fellow Sectional Delegate(s)
  Benjamin Meyer, Milwaukee WI

Regional Medical Student Delegate(s)
  Michael Rigby, Madison WI

Regional Medical Student Alternate Delegate(s)
  Nathan J Carpenter, Milwaukee WI

Wyoming Medical Society

Delegate(s)
  Stephen Brown, Casper WY

Alternate Delegate(s)
  Paul Johnson, Cheyenne WY

This list does not reflect temporary changes for this meeting.
Academy of Physicians in Clinical Research
Delegate(s)
Peter Howard Rheinstein, Severna Park MD
Alternate Delegate(s)
Hugh H. Tilson, Chapel Hill NC

Aerospace Medical Association
Delegate(s)
Hernando J. Ortega, Jr, San Antonio TX
Alternate Delegate(s)
Daniel Shoor, San Antonio TX

Air Force
Delegate(s)
Paul Friedrichs, Saint Louis MO

AMDA-The Society for Post-Acute and Long-Term Care Medicine
Delegate(s)
Rajeev Kumar, Oak Brook IL
Alternate Delegate(s)
Eric Tangalos, Rochester MN

American Academy of Allergy, Asthma & Immunology
Delegate(s)
Steven G. Tolber, Corrales NM
Alternate Delegate(s)
George Green, Abington PA

American Academy of Child and Adolescent Psychiatry
Delegate(s)
David Fassler, Burlington VT
Louis Kraus, Chicago IL
Alternate Delegate(s)
Sharon L. Hirsch, Chicago IL

American Academy of Cosmetic Surgery
Delegate(s)
Anthony J. Geroulis, Northfield IL
Alternate Delegate(s)
Robert F. Jackson, Noblesville IN

American Academy of Dermatology
Delegate(s)
Hillary Johnson-Jahangir, Iowa City IA

This list does not reflect temporary changes for this meeting.
American Academy of Hospice and Palliative Medicine
Delegate(s)
Chad D. Kollas, Orlando FL

American Academy of Insurance Medicine
Delegate(s)
Deborah Y. Smart, Gurnee IL

American Academy of Neurology
Delegate(s)
Nicholas Johnson, Salt Lake City UT
Shannon Kilgore, Palo Alto CA
Mark Milstein, New York NY
Alternate Delegate(s)
Daniel George, Springfield MA

American Academy of Ophthalmology
Delegate(s)
Kevin T. Flaherty, Wausau WI
Ravi Goel, Cherry Hill NJ
Lisa Nijm, Warrenville IL
Mildred M G. Olivier, Arlington Heights IL

American Academy of Otolaryngic Allergy
Delegate(s)
Wesley Dean. VanderArk, Camp Hill PA

American Academy of Otolaryngology-Head and Neck Surgery
Delegate(s)
Craig Derkay, Norfolk VA

American Academy of Otolaryngology-Head and Neck Surgery
Delegate(s)
Douglas R. Myers, Vancouver WA
Robert Puchalski, Lugoff SC
Alternate Delegate(s)
James C. Dennen, Alexandria VA

American Academy of Pain Medicine
Delegate(s)
Robert Wailes, Rancho Santa Fe CA
Alternate Delegate(s)
Donna Bloodworth, Alvin TX

American Academy of Pediatrics
Delegate(s)
Toluwalase Ajayi, San Diego CA
Charles Barone, Ira MI
Carol Berkowitz, Rancho Palos Verdes CA
Melissa J. Garretson, Fort Worth TX
Zarah Iqbal, Gladwyne PA
Colleen Kraft, Mission Viejo CA
Samantha Rosman, Jamaica Plain MA
David T. Tayloe, Jr, Goldsboro NC
Alternate Delegate(s)
Karen Remley, Richmond VA

Resident and Fellow Sectional Delegate(s)
Scott Resnick, Brookline MA

Resident and Fellow Sectional Alternate Delegate(s)
Sarah Marsicek, Petersburg FL

American Academy of Physical Medicine and Rehabilitation
Delegate(s)
Stuart Glassman, Concord NH
Susan L. Hubbell, Lima OH
Alternate Delegate(s)
Brittany Bickelhaupt, San Antonio TX

American Academy of Psychiatry and the Law
Delegate(s)
Barry Wall, Providence RI

Alternate Delegate(s)
Jennifer Piel, Seattle WA

This list does not reflect temporary changes for this meeting.
<table>
<thead>
<tr>
<th>Association</th>
<th>Delegate(s)</th>
<th>Alternate Delegate(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Association for Geriatric Psychiatry</td>
<td>Allan Anderson, Easton MD</td>
<td>Sandra Swantek, Chicago IL</td>
</tr>
<tr>
<td>American Association for Hand Surgery</td>
<td>Peter C. Amadio, Rochester MN</td>
<td>Nicholas B. Vedder, Seattle WA</td>
</tr>
<tr>
<td>American Association for Thoracic Surgery</td>
<td>Daniel M. Meyer, Dallas TX</td>
<td></td>
</tr>
<tr>
<td>American Association of Clinical Endocrinologists</td>
<td>Jonathan D. Leffert, Dallas TX</td>
<td>John A. Seibel, Los Ranchos NM</td>
</tr>
<tr>
<td>American Association of Clinical Urologists</td>
<td>Richard S. Pelman, Bellevue WA</td>
<td>Patrick H. McKenna, Madison WI</td>
</tr>
<tr>
<td>American Association of Gynecologic Laparoscopists</td>
<td>Joseph M. Maurice, Chicago IL</td>
<td></td>
</tr>
<tr>
<td>American Association of Neurological Surgeons</td>
<td>Kenneth S. Blumenfeld, San Jose CA</td>
<td>Maya A. Babu, Miami FL</td>
</tr>
<tr>
<td>American Association of Neuromuscular &amp; Electrodiagnostic Medicine</td>
<td>William Pease, Columbus OH</td>
<td>Enrica Arnaudo, Newark DE</td>
</tr>
<tr>
<td>American Association of Physicians of Indian Origin</td>
<td>VijayaLakshmi Appareddy, Chattanooga TN</td>
<td>Subhash Chandra, Amityville NY</td>
</tr>
<tr>
<td>American Association of Plastic Surgeons</td>
<td>Gregory L. Borah, New Brunswick NJ</td>
<td>Michele Manahan, Baltimore MD</td>
</tr>
<tr>
<td>American Association of Public Health Physicians</td>
<td>Dave Cundiff, Olympia WA</td>
<td>Arlene Seid, Grantham PA</td>
</tr>
<tr>
<td>American Clinical Neurophysiology Society</td>
<td>Marc Nuwer, Los Angeles CA</td>
<td>Jaime Lopez, Stanford CA</td>
</tr>
<tr>
<td>American College of Allergy, Asthma and Immunology</td>
<td>Alnoor A. Malick, Houston TX</td>
<td>John M. Seyerle, Cincinnati OH</td>
</tr>
<tr>
<td>American College of Cardiology</td>
<td>Benjamin Galper, Potomac MD</td>
<td>Jerry D. Kennett, Columbia MO</td>
</tr>
<tr>
<td></td>
<td>Suma Thomas, Cleveland OH</td>
<td>L. Samuel Wann, Whitefish Bay WI</td>
</tr>
<tr>
<td></td>
<td>Kim Allan Williams, Chicago IL</td>
<td></td>
</tr>
<tr>
<td>American College of Public Health Physicians</td>
<td></td>
<td>James W. Fasules, Washington DC</td>
</tr>
<tr>
<td></td>
<td>David Winchester, Gainesville FL</td>
<td></td>
</tr>
</tbody>
</table>

Resident and Fellow Sectional Delegate(s)

Aaron Kithcart, Boston MA

This list does not reflect temporary changes for this meeting.
American College of Chest Physicians (CHEST)
Delegate(s)
Neeraj Desai, Schaumburg IL
D Robert McCaffree, Oklahoma City OK

American College of Emergency Physicians
Delegate(s)
Michael D. Bishop, Bloomington IN
Brooks F. Bock, Vail CO
Stephen K. Epstein, Boston MA
Michael J. Gerardi, Hackettstown NJ
John C. Moorhead, Portland OR
Reid Orth, Alexandria VA
Jennifer L. Wiler, Aurora CO
Alternate Delegate(s)
Nancy J. Auer, Mercer Island WA
Erick Eiting, New York NY
Paul Kivela, Napa CA

American College of Gastroenterology
Delegate(s)
R Bruce Cameron, Chagrin Falls OH
March Seabrook, West Columbia SC

American College of Legal Medicine
Delegate(s)
Richard Wilbur, Lake Forest IL
Alternate Delegate(s)
Victoria L. Green, Stone Mountain GA

American College of Medical Genetics & Genomics
Delegate(s)
Reed E. Pyeritz, Philadelphia PA
Alternate Delegate(s)
R Rodney Howell, Miami FL

American College of Medical Quality
Delegate(s)
Donald E. Casey, Jr, Chicago IL
Alternate Delegate(s)
Beverly Collins, E New Market MD

American College of Mohs Surgery
Delegate(s)
Michel McDonald, Nashville TN

American College of Mohs Surgery
Alternate Delegate(s)
Divya Srivastava, Dallas TX

Resident and Fellow Sectional Alternate Delegate(s)
Keena Que, Brookline MA

American College of Nuclear Medicine
Delegate(s)
Alain Klitzke, Buffalo NY

American College of Obstetricians and Gynecologists
Delegate(s)
Dana Block-Abraham, Baltimore MD
Carol L. Brown, New York NY
C. Blair Harkness, Asheville NC
Joseph M. Heyman, West Newbury MA
Nita Kulkarni, Flint MI
Mary E. LaPlante, Broadview Heights OH
Barbara S. Levy, Washington DC
G. Sealy Massingill, Fort Worth TX
Diana Ramos, Laguna Beach CA
Kasandra Scales, Alexandria VA
Heather Smith, New York NY
Robert Wah, McLean VA
Alternate Delegate(s)
Richard Allen, Portland OR
Hal Lawrence, Washington DC
Brandi Ring, Denver CO

Resident and Fellow Sectional Delegate(s)
Daisy Hassani, Cleveland OH
Resident and Fellow Sectional Alternate Delegate(s)
Melanie Mita, Ocala FL

American College of Occupational and Environmental Medicine
Delegate(s)
Robert Orford, Scottsdale AZ
Alternate Delegate(s)
Kathryn Lucile Mueller, Denver CO

American College of Phlebology
Delegate(s)
Christopher Pittman, Tampa FL

This list does not reflect temporary changes for this meeting.
American College of Physicians
Delegate(s)
George Abraham, Worcester MA
Micah Beachy, Omaha NE
Sue Bornstein, Dallas TX
Sarah G. Candler, Charlottesville VA
Chelsea Cockburn, Richmond VA
Charles Cutler, Merion Sta PA
Nitin S Damle, Wakefield RI
Noel N. Deep, Antigo WI
Andrew Dunn, Montebello NY
Yul D. Ejnes, N Scituate RI
Jacqueline Fincher, Thomson GA
Richard S. Frankenstein, Santa Ana CA
Sandra Fryhofer, Atlanta GA
William E. Golden, Little Rock AR
Tracey Henry, Powder Springs GA
Mary T. Herald, Summit NJ
Susan Hingle, Springfield IL
Lynne M. Kirk, Dallas TX
J Leonard Lichtenfeld, Atlanta GA
Ana Maria Lopez, Salt Lake City UT
Robert McLean, New Haven CT
Donna E. Sweet, Wichita KS
Mary Anderson Wallace, Colorado Springs CO
Alternate Delegate(s)
Darilin Moyer, Lafayette HI PA
Jacob Quinton, New Haven CT

American College of Preventive Medicine
Delegate(s)
Robert Gilchick, Los Angeles CA
Alternate Delegate(s)
Jason M. Spangler, Arlington VA

American College of Radiation Oncology
Delegate(s)
Dennis Galinsky, Chicago IL
Alternate Delegate(s)
Mohamed Khan, Gilbert AZ

American College of Radiology
Delegate(s)
Todd M. Hertzberg, Pittsburgh PA
Daniel H. Johnson, Jr, Metairie LA
Arl Van. Moore, Jr, Charlotte NC
Raymond Wynn, Maywood IL
Alternate Delegate(s)
Gregory W. Cotter, Southaven MS
Howard B. Fleishon, Phoenix AZ
Geraldine Mc Ginty, New York NY

Resident and Fellow Sectional Delegate(s)
Monica Wood, Boston MA

Resident and Fellow Sectional Alternate Delegate(s)
Gunjan Malhotra, Canton MI

American College of Rheumatology
Delegate(s)
Gary L. Bryant, Minnetonka MN
Eileen M. Moynihan, Woodbury NJ
Alternate Delegate(s)
Cristina G Arriens, Edmond OK

American College of Surgeons
Delegate(s)
Brian Gavitt, Cincinnati OH
David B. Hoyt, Chicago IL
Jacob Moalem, Rochester NY
Leigh A. Neumayer, Tucson AZ
Naveen Sangji, Boston MA
Patricia Turner, Chicago IL

American Gastroenterological Association
Delegate(s)
Peter N. Kaufman, Bethesda MD

American Geriatrics Society
Delegate(s)
Eugene Lammers, Mobile AL

American Institute of Ultrasound in Medicine
Delegate(s)
David P. Bahner, Columbus OH
Marilyn Laughead, Scottsdale AZ

This list does not reflect temporary changes for this meeting.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Delegate(s)</th>
<th>Alternate Delegate(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Medical Group Association</td>
<td>Randall Gibb, Billings MT</td>
<td>Samuel Lin, Alexandria VA</td>
</tr>
<tr>
<td></td>
<td>Lynn Vaughn, Mitchell, Oklahoma City OK</td>
<td></td>
</tr>
<tr>
<td>American Medical Women's Association</td>
<td>Nancy Church, Oak Lawn IL</td>
<td>Neelum Aggarwal, Chicago IL</td>
</tr>
<tr>
<td>American Orthopaedic Association</td>
<td>Norman Chutkan, Phoenix AZ</td>
<td></td>
</tr>
<tr>
<td>American Orthopaedic Foot and Ankle Society</td>
<td>Michael S. Aronow, West Hartford CT</td>
<td>Christopher Chiodo, Walpole MA</td>
</tr>
<tr>
<td>American Osteopathic Association</td>
<td>Mark A. Baker, Fort Worth TX</td>
<td>William Sumners Mayo, Oxford MS</td>
</tr>
<tr>
<td>American Psychiatric Association</td>
<td>Jeffrey Akaka, Honolulu HI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kenneth M. Certa, Philadelphia PA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jerry L. Halverson, Oconomowoc WI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ray Hsiao, Bellevue WA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carolyn B. Robinowitz, Washington DC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Barbara Schneidman, Seattle WA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>John Wernert, III, Louisville KY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rebecca Brendel, Brookline MA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Saul M. Levin, Washington DC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Theresa M. Miskimen, Millstone Twp NJ</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paul O'Leary, Birmingham AL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bruce Schwartz, Bronx NY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ravi Navin Shah, New York NY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Harsh Trivedi, Nashville TN</td>
<td></td>
</tr>
<tr>
<td>American Psychiatric Association</td>
<td>Laura Halpin, Playa Del Rey CA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laurel Bessey, Madison WI</td>
<td></td>
</tr>
<tr>
<td>American Roentgen Ray Society</td>
<td>Denise Collins, Detroit MI</td>
<td></td>
</tr>
<tr>
<td>American Society for Aesthetic Plastic Surgery</td>
<td>Gary J. Price, Guilford CT</td>
<td></td>
</tr>
<tr>
<td>American Society for Clinical Pathology</td>
<td>Edmund R. Donoghue, Jr, Savannah GA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>David Lewin, Charleston SC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>James L. Wisecarver, Omaha NE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>William G. Finn, Ann Arbor MI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steven H. Kroft, Mequion WI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fred H. Rodriguez, Jr, Metairie AL</td>
<td></td>
</tr>
<tr>
<td>American Society for Dermatologic Surgery</td>
<td>Jessica Krant, New York NY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anthony Rossi, Jr, New York NY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chad Prather, Baton Rouge LA</td>
<td></td>
</tr>
<tr>
<td>American Society for Gastrointestinal Endoscopy</td>
<td>Maurice A. Cerulli, Rockville Center NY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Walter G. Park, Los Altos CA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Donald A. O'Kieffe, Jr, Washington DC</td>
<td></td>
</tr>
<tr>
<td>American Society for Metabolic and Bariatric Surgery</td>
<td>Christopher Joyce, New Lenox IL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bipan Chand, Maywood IL</td>
<td></td>
</tr>
</tbody>
</table>

This list does not reflect temporary changes for this meeting.
American Society for Radiation Oncology
Delegate(s)
Shilpen A. Patel, Redwood CA
Alternate Delegate(s)
Shane Hopkins, Ames IA

American Society for Reproductive Medicine
Delegate(s)
Julia V. Johnson, Worcester MA
Alternate Delegate(s)
Eric Levens, Rockville MD

American Society for Surgery of the Hand
Delegate(s)
David Lichtman, Ft Worth TX
Alternate Delegate(s)
Robert C. Kramer, Beaumont TX

American Society of Abdominal Surgeons
Delegate(s)
Philip E. McCarthy, Norwood MA

American Society of Addiction Medicine
Delegate(s)
Stuart Gitlow, New York NY
Alternate Delegate(s)
Ilse R. Levin, Washington DC

American Society of Anesthesiologists
Delegate(s)
Jane C K. Fitch, Oklahoma City OK
Tripti C. Kataria, Chicago IL
Candace E. Keller, Miramar Beach FL
John B. Neeld, Jr, Atlanta GA
Michael B. Simon, Wappingers Falls NY
Gary D. Thal, Chicago IL
Alternate Delegate(s)
Jennifer Bartlotti-Telesz, Temecula CA
Randall M. Clark, Denver CO
Ronald Harter, Dublin OH
Mary Dahlen Peterson, Corpus Christi TX
Kevin E. Vorenkamp, Seattle WA
Crystal C. Wright, Houston TX
Resident and Fellow Sectional Delegate(s)
Matthew Mcnelley, Wichita KS

American Society of Anesthesiologists
Resident and Fellow Sectional Alternate Delegate(s)
Toyin Okanlawon, Atlanta GA

American Society of Breast Surgeons
Delegate(s)
Steven Chen, San Diego CA

American Society of Cataract and Refractive Surgery
Delegate(s)
Parag D. Parekh, Dubois PA

American Society of Clinical Oncology
Delegate(s)
Edward P. Balaban, State College PA
Thomas A. Marsland, Orange Park FL
Ray D. Page, Fort Worth TX
Alternate Delegate(s)
Morganna L. Freeman, W Hollywood CA
Steve Y. Lee, New York NY
Kristina Novick, Rochester NY
Resident and Fellow Sectional Alternate Delegate(s)
Erin Schwab, Chicago IL

American Society of Colon and Rectal Surgeons
Delegate(s)
Ronald Gagliano, Phoenix AZ
Alternate Delegate(s)
Harry Papaconstantinou, Temple TX

American Society of Dermatopathology
Delegate(s)
Melissa Piland, Cleveland OH
Alternate Delegate(s)
Karl Napekoski, Naperville IL

American Society of Echocardiography
Delegate(s)
Peter S. Rahko, Madison WI
Alternate Delegate(s)
Kameswari Maganti, Chicago IL

This list does not reflect temporary changes for this meeting.
American Society of General Surgeons
Delegate(s)
Albert M. Kwan, Clovis NM

American Society of Hematology
Delegate(s)
Chancellor Donald, Lafayette LA
Gamini S. Soori, Omaha NE
Resident and Fellow Sectional Delegate(s)
Amar Kelkar, Peoria IL

American Society of Interventional Pain Physicians
Delegate(s)
Lee Snook, Sacramento CA
Alternate Delegate(s)
Sachin Jha, Tustin CA
Resident and Fellow Sectional Delegate(s)
Michael C. Lubrano, San Francisco CA
Resident and Fellow Sectional Alternate Delegate(s)
Alberto Bursian, Gainesville FL

American Society of Maxillofacial Surgeons
Delegate(s)
Victor L. Lewis, Jr, Chicago IL
Alternate Delegate(s)
Kant Lin, Charlottesville VA

American Society of Neuroradiology
Delegate(s)
Jacqueline Anne Bello, New York NY
Alternate Delegate(s)
Christie M. Lincoln, Houston TX

American Society of Ophthalmic Plastic and Reconstructive Surgery
Delegate(s)
John N. Harrington, Dallas TX
Alternate Delegate(s)
Erin Shriver, Iowa City IA

American Society of Plastic Surgeons
Delegate(s)
C. Bob Basu, Houston TX
Robert J. Havlik, Mequon WI

American Society of Plastic Surgeons
Alternate Delegate(s)
Raj Ambay, Wesley Chapel FL
Resident and Fellow Sectional Delegate(s)
Sean Figy, Worcester MA

American Society of Retina Specialists
Delegate(s)
Michael J. Davis, Arcadia CA
Alternate Delegate(s)
Joe Nezgoda, Jr, West Palm Beach FL

American Society of Transplant Surgeons
Delegate(s)
Thomas G. Peters, Jacksonville FL
Alternate Delegate(s)
Stuart M. Greenstein, Bronx NY

American Thoracic Society
Delegate(s)
Ajanta Patel, Chicago IL
Dean E. Schraufnagel, Jr, Chicago IL

American Urological Association
Delegate(s)
Aaron Spitz, Laguna Hills CA
Willie Underwood, III, Williamsville NY
Alternate Delegate(s)
Terrence Robert Grimm, Lexington KY
Roger W. Satterthwaite, S Pasadena CA
Resident and Fellow Sectional Delegate(s)
Hans C. Arora, Cleveland OH

AMSUS The Society of Federal Health Professionals
Delegate(s)
John Cho, Bethesda MD

Army
Delegate(s)
Michael R. Nelson, Olney MD
Alternate Delegate(s)
Kent Dezee, Bethesda MD

Association of University Radiologists
Delegate(s)
Stephen Chan, Closter NJ

This list does not reflect temporary changes for this meeting.
Association of University Radiologists
Resident and Fellow Sectional Delegate(s)
Naiim S. Ali, Burlington VT

College of American Pathologists
Delegate(s)
James L. Caruso, Castle Rock CO
William V. Harrer, Haddonfield NJ
Mark S. Synovec, Topeka KS
Alternate Delegate(s)
Jean Elizabeth Forsberg, Pineville LA
Susan Strate, Wichita Falls TX
Resident and Fellow Sectional Alternate Delegate(s)
Rebecca Obeng, Atlanta GA

Congress of Neurological Surgeons
Delegate(s)
Ann R. Stroink, Bloomington IL
Alternate Delegate(s)
Krystal L. Tomei, Lyndhurst OH

Contact Lens Association of Ophthalmologists
Delegate(s)
Melvin I Freeman, Bellevue WA
Alternate Delegate(s)
S Lance Forstot, Littleton CO

Endocrine Society, The
Delegate(s)
Amanda Bell, Kansas City MO
Daniel Spratt, Portland ME
Alternate Delegate(s)
Robert Vigersky, Washington DC

GLMA
Delegate(s)
Jeremy Toler, New Orleans LA
Alternate Delegate(s)
Desiray C. Bailey, Des Moines WA

Heart Rhythm Society
Delegate(s)
Steve Hao, San Francisco CA
Alternate Delegate(s)
Jim Cheung, New York NY

Infectious Diseases Society of America
Delegate(s)
Michael L. Butera, San Diego CA
Steven W. Parker, Reno NV
Alternate Delegate(s)
Nancy Crum, Poway CA
Resident and Fellow Sectional Delegate(s)
Megan Srinivas, Chapel Hill NC

International Academy of Independent Medical Evaluators
Delegate(s)
Douglas Martin, Sioux City IA
Alternate Delegate(s)
Marjorie Eskay-Auerbach, Tucson AZ

International College of Surgeons-US Section
Delegate(s)
Raymond A. Dieter, Jr, Glen Ellyn IL
Alternate Delegate(s)
Wickii Vigneswaran, Maywood IL

International Society for the Advancement of Spine Surgery
Delegate(s)
Morgan P. Lorio, Nashville TN

International Society of Hair Restoration Surgery
Delegate(s)
Carlos J. Puig, Houston TX
Alternate Delegate(s)
Ricardo Mejia, Jupiter FL

National Association of Medical Examiners
Delegate(s)
J Scott. Denton, Bloomington IL

National Medical Association
Delegate(s)
Sandra L. Gadson, Merrillville IN
Alternate Delegate(s)
Gary Dennis, Frisco TX

Navy
Delegate(s)
Paul D. Pearigen, San Dieg CA

This list does not reflect temporary changes for this meeting.
Navy
Alternate Delegate(s)
Christopher Quarles, FPO AE

North American Spine Society
Delegate(s)
R Dale Blasier, Little Rock AR
William Mitchell, Mount Laurel NJ

Obesity Medicine Association
Delegate(s)
Ethan Lazarus, Greenwood Village CO
Alternate Delegate(s)
Fatima Cody Stanford, Boston MA

Radiological Society of North America
Delegate(s)
Michael C. Brunner, Madison WI
Kevin C. Reilly, Sr, Elizabethtown KY
Laura E. Traube, Templeton CA

Renal Physicians Association
Delegate(s)
Louis H. Diamond, Rockville MD
Alternate Delegate(s)
Rebecca Schmidt, Morgantown WV

Society for Cardiovascular Angiography and Interventions
Delegate(s)
Joseph D. Babb, Winterville NC
Alternate Delegate(s)
Clifford Kavinsky, Chicago IL

Society for Investigative Dermatology
Delegate(s)
Daniel Bennett, Madison WI
Alternate Delegate(s)
Erica Dommasch, Boston MA

Society for Vascular Surgery
Delegate(s)
Mark D. Morasch, Billings MT
Alternate Delegate(s)
Timothy F. Kresowik, Iowa City IA

Society of American Gastrointestinal Endoscopic Surgeons
Delegate(s)
Paresh Shah, New York NY
Alternate Delegate(s)
Eli Lerner, Jacksonville FL

Society of Critical Care Medicine
Delegate(s)
Russell C. Raphaely, Wilmington DE
Tina R. Shah, Atlanta GA
Resident and Fellow Sectional Delegate(s)
Kathleen Doo, New York NY

Society of Hospital Medicine
Delegate(s)
Steven Deitelzweig, New Orleans LA
Brad Flansbaum, Danville PA

Society of Interventional Radiology
Delegate(s)
Meridith Englander, Albany NY
Alternate Delegate(s)
Terence Matalon, Philadelphia PA
Resident and Fellow Sectional Delegate(s)
Natosha Monfore, Edmond OK
Resident and Fellow Sectional Alternate Delegate(s)
Andrew Klobuka, Pittsburgh PA

Society of Laparoendoscopic Surgeons
Delegate(s)
Camran Nezhat, Palo Alto CA

Society of Nuclear Medicine and Molecular Imaging
Delegate(s)
Gary L. Dillehay, Chicago IL
Alternate Delegate(s)
Hazem H. Chehabi, Newport Beach CA

Society of Thoracic Surgeons
Delegate(s)
Robert M. Vanecko, Chicago IL
Alternate Delegate(s)
Jeffrey P. Gold, Omaha NE

This list does not reflect temporary changes for this meeting.
Spine Intervention Society
Delegate(s)
Claire Tibiletti, Tyler TX
Alternate Delegate(s)
Kate Sully, Portage MI

Undersea and Hyperbaric Medical Society
Delegate(s)
Laurie Gesell, Brookfield WI
Alternate Delegate(s)
Lisa Gould, Warwick RI

US and Canadian Academy of Pathology
Delegate(s)
Nicole Riddle, Tampa FL
Daniel Zedek, Chapel Hill NC
Alternate Delegate(s)
Keagan H. Lee, Houston TX
Nirali M. Patel, Durham NC

Resident and Fellow Sectional Alternate Delegate(s)
Valerie Lockhart, Shreveport LA

US Public Health Service
Delegate(s)
Brian M Lewis, Silver Spring MD

Veterans Affairs
Delegate(s)
Carolyn M. Clancy, Washington DC

This list does not reflect temporary changes for this meeting.
**Academic Physicians Section**
Delegate(s)
Kenneth B. Simons, Milwaukee WI
Alternate Delegate(s)
Donald G. Eckhoff, Aurora CO

**Integrated Physician Practice Section**
Delegate(s)
Russell C. Libby, Fairfax VA
Alternate Delegate(s)
Devdutta Sangvai, Durham NC

**International Medical Graduates Section**
Delegate(s)
Kevin King, Miami FL
 Alternate Delegate(s)
Ronit Katz, Cupertino CA

**Medical Student Section**
Delegate(s)
Jerome Jeevarajan, Dallas TX
Alternate Delegate(s)
Kieran Mc Avoy, Brookfield WI

**Minority Affairs Section**
Delegate(s)
Dionne Hart, Rochester MN
Alternate Delegate(s)
Frank Alexander Clark, Simpsonville SC

**Organized Medical Staff Section**
Delegate(s)
Matthew Gold, Winchester MA

**Resident and Fellow Section**
Delegate(s)
Joshua Lesko, San Diego CA
Alternate Delegate(s)
George Taylor Desrosiers, Portsmouth VA

**Senior Physicians Section**
Delegate(s)
Claire V. Wolfe, Dublin OH
Alternate Delegate(s)
John A. Knote, West Lafayette IN

**Women Physicians Section**
Delegate(s)
Josephine Nguyen, Vernon Hills IL
Alternate Delegate(s)
Ami A. Shah, Brooklyn NY

**Young Physicians Section**
Delegate(s)
Hilary E. Fairbrother, Houston TX
Alternate Delegate(s)
Kavita Arora, Cleveland Hts OH

*This list does not reflect temporary changes for this meeting.*
REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES (A-18)

Reference Committee on Amendments to Constitution and Bylaws
Peter H. Rheinstein, MD, JD, Acad. of Physicians in Clinical Research, Chair
Mark Adams, MD, New York*
Thomas M. Anderson, Jr., MD, Illinois
Douglas R. Myers, MD, Amer. Acad. of Otolaryngology-Head and Neck Surgery
Camran Nezhat, MD, Soc. of Laparoendoscopic Surgeons
Robert Panton, MD, Illinois*
Brandi N. Ring, MD, Amer. Coll. of Obstetricians and Gynecologists*

Reference Committee A (Medical Service)
Jonathan D. Leffert, MD, Amer. Assoc. of Clinical Endocrinologists, Chair
Toluwalase Ajayi, MD, Amer. Acad. of Pediatrics
Peter Aran, MD, Oklahoma*
Micah Beachy, DO, Amer. Coll. of Physicians
Christine P. Bishop, MD, Illinois*
Maryanne C. Bombaugh, MD, Massachusetts
Beverly Collins, MD, Amer. Coll. of Medical Quality*

Reference Committee B (Legislation)
R. Dale Blasier, MD, North Amer. Spine Society, Chair
Edward P. Balaban, DO, Amer. Soc. of Clinical Oncology
Erin Harnish, MD, Washington
Mark Kogan, MD, California*
William Monnig, MD, Kentucky*
Gary Pushkin, MD, Maryland*
Luis Seija, Texas, Regional Medical Student

Reference Committee C (Medical Education)
Sherri Baker, MD, Oklahoma, Chair
Grayson Armstrong, MD, Amer. Acad. of Ophthalmology, Sectional Resident
Cheryl Gibson Fountain, MD, Michigan*
Alan Klitzke, MD, Amer. Coll. of Nuclear Medicine
David Lewin, MD, Amer. Soc. for Clinical Pathology
Kim Templeton, MD, Amer. Acad. of Orthopaedic Surgeons
Jessica Walsh-O’Sullivan, Florida, Regional Medical Student

Reference Committee D (Public Health)
Shannon M. Kilgore, MD, Amer. Acad. of Neurology, Chair
Deepak G. Azad, MD, Indiana*
Reid Orth, MD, Amer. Coll. of Emergency Physicians
Diana E. Ramos, MD, Amer. Coll. of Obstetricians and Gynecologists
Cynthia C. Romero, MD, Virginia*
Ralph Schmeltz, MD, Pennsylvania
Victoria Sharp, MD, Iowa

Reference Committee E (Science and Technology)
Douglas W. Martin, MD, International Acad. of Independent Medical Evaluators, Chair
Allan A. Anderson, MD, Amer. Assoc. for Geriatric Psychiatry
Jessica Cho, MD, New York*, Sectional Resident
Robert H. Emmick, Jr., MD, Texas*
Meredith Englander, MD, Soc. of Interventional Radiology
Jean Elizabeth Forsberg, MD, Coll. of Amer. Pathologists*
J. Leonard Lichtenfeld, MD, Amer. Coll. of Physicians

Reference Committee F (AMA Finance; AMA Governance)
Julia V. Johnson, MD, Amer. Soc. for Reproductive Medicine, Chair
Anthony J. Armstrong, MD, Ohio
A. Patrice Burgess, MD, Idaho
Melissa J. Garretson, MD, Amer. Acad. of Pediatrics
Jerry L. Halverson, MD, Amer. Psychiatric Assoc.
Ann R. Stroink, MD, Congress of Neurological Surgeons
Greg Tarasidis, MD, South Carolina

Reference Committee G (Medical Practice)
Theodore A. Calianos, II, MD, Massachusetts, Chair
Joseph A. Adashek, MD, Nevada*
Steven M. Falcone, MD, Amer. Coll. of Radiology
Brian Gavitt, MD, Amer. Coll. of Surgeons
Kathryn Lombardo, MD, Minnesota*
Michele Manahan, MD, Amer. Assoc. of Plastic Surgeons*
Peter S. Rahko, MD, Amer. Soc. of Echocardiography

Committee on Rules and Credentials
John M. Montgomery, MD, Florida, Chair
Jerome C. Cohen, MD, New York
Sharon Douglas, MD, Mississippi*
Jan Marie Kief, MD, Colorado
Stephen Richards, DO, American Academy of Family Physicians
William Ritchie, MD, New Mexico*
Cyndi J. Yag Howard, MD, American Academy of Dermatology

Chief Teller
James Bull, MD, Illinois

* Alternate Delegate
FIRST SESSION, Saturday, June 9, 2:00 – 6:00 pm

SECOND SESSION, Sunday, June 10, 8:00 – 8:30 am

THIRD SESSION, Monday, June 11, 2:00 – 6:00 pm

FOURTH SESSION, Tuesday, June 12, 9:00 am – 3 pm

Note: The Inauguration of Barbara L. McAneny, MD, as the 173rd President of the American Medical Association, will be held at 5:00 pm in the Crystal Ballroom of the Hyatt Regency Chicago.

FIFTH SESSION, Wednesday, June 13, 9:00 am – noon
SUMMARY OF FISCAL NOTES (A-18)

BOT Report(s)

01 Annual Report: Minimal
02 New Specialty Organizations Representation in the House of Delegates: Minimal
03 2017 Grants and Donations: Informational Report
04 AMA 2019 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 2017: Informational Report
08 Annual Update on Activities and Progress in Tobacco Control: March 2017 Through February 2018: Informational Report
10 Over-the-Counter Contraceptive Drug Access: Minimal
11 Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States: Minimal
12 Advocacy for Seamless Interface Between Physician Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs: Minimal
13 Mergers of Secular and Religiously Affiliated Health Care Institutions and Their Impact on Patient Care and Access to Services: Minimal
14 Integration of Drug Price Information into Electronic Medical Records / Barriers to Price Transparency / Bidirectional Communication for EHR Software and Pharmacies / Health Plan, Pharmacy, Electronic Health Records Integration: Modest
15 Advanced Practice Registered Nurse Compact: Minimal
16 Protection of Clinician-Patient Privilege: Minimal
17 Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care: Minimal
18 Medical Liability Coverage Through the Federal Tort Claims Act: Minimal
19 Health Information Technology Principles: Modeest
20 Anti-Harassment Policy: Minimal
21 Ownership of Patient Data: Informational Report
22 In-Flight Emergencies: Minimal
23 Healthcare as a Human Right: Minimal
24 Appropriate Placement of Transgender Prisoners: Minimal
25 Recognition of Physician Orders for Life Sustaining Treatment Forms: Modest
26 Revision of Researcher Certification and Institutional Review Board Protocols: Minimal
27 Policy and Economic Support for Early Child Care: Minimal
28 Mandatory Public Health Reporting of Law-Enforcement-Related Injuries and Deaths: Minimal
29 Support for Service Animals, Emotional Support Animals, Animals in Healthcare and Medical Benefits of Pet Ownership: Minimal
30 In-Flight Emergencies: Minimal
31 Physician Burnout and Wellness Challenges, Physician and Physician Assistant Safety Net, Identification and Reduction of Physician Demoralization: Minimal
32 Studying Healthcare Institutions that Provide Child Care Services: Informational Report
33 Plan for Continued Progress Toward Health Equity: $1,000,000 annually
34 AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies: Minimal
35 Model Hospital Medical Staff Bylaws: Moderate
36 Management of Physician and Medical Student Stress: Informational Report
37 Eliminate the Requirement of H&P Update: Minimal
38 Timely Referral to Pain Management Specialist: Minimal
39 Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models: Minimal
SUMMARY OF FISCAL NOTES (A-18)

BOT Report(s)
40 Medicare Coverage of Services Provided by Proctored Medical Students: Minimal
41 Augmented Intelligence in Health Care: Modest

CC&B Report(s)
01 CCB Sunset Review of 2008 House Policies: Minimal

CEJA Opinion(s)
01 Ethical Physician Conduct in the Media: n/a

CEJA Report(s)
01 Competence, Self-Assessment and Self-Awareness: Minimal
02 Mergers of Secular and Religiously Affiliated Health Care Institutions: Minimal
03 Medical Tourism: Minimal
04 Expanded Access to Investigational Therapies: Minimal
05 Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician Assisted Suicide" and "Aid in Dying": Minimal
06 CEJA's Sunset Review of 2008 House Policies: Minimal

CLRPD Report(s)
01 A Primer on Artificial and Augmented Intelligence: Informational Report

CME Report(s)
01 Council on Medical Education Sunset Review of 2008 House of Delegates Policies: Minimal
02 Update on Maintenance of Certification and Osteopathic Continuous Certification: Modest
03 Expanding UME Without Concurrent GME Expansion: Minimal
04 Evaluation of Clinical Documentation Training: Minimal
05 Study of Declining Native American Medical Student Enrollment: Info Report
06 Mental Health Disclosures on Physician Licensing Applications: Minimal

CMS Report(s)
01 Council on Medical Service Sunset Review of 2008 AMA House Policies: Minimal
02 Improving Affordability in the Health Insurance Exchanges: Minimal
03 Ensuring Marketplace Competition and Health Plan Choice: Minimal
04 Health Plans' Medical Advice: Minimal
05 Financing of Long-Term Services and Supports: Minimal
06 Integrating Precision Medicine into Alternative Payment Models: Minimal
07 Insulin Affordability: Minimal
08 Addressing the Site-of-Service Differential: Info Report

CSAPH Report(s)
01 CSAPH Sunset Review of 2008 House of Delegates Policies: Minimal
SUMMARY OF FISCAL NOTES (A-18)

CSAPH Report(s)
02 Drug Shortages: Update: Minimal
03 Prescription Drug Donation: Minimal
04 The Physician's Role in Firearm Safety: Minimal
05 Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking: Minimal

Joint Report(s)
01 CMS/CSAPH Joint Report - Coverage for Colorectal Cancer Screening: Modest

Report of the Speakers
01 Recommendations for Policy Reconciliation: Informational Report

Resolution(s)
001 Discriminatory Policies that Create Inequities in Health Care: Minimal
002 FMLA-Equivalent for LGBT Workers: Minimal
003 Proposing Consent for De-Identified Patient Information: Modest
004 Patient-Reported Outcomes in Gender Confirmation Surgery: Minimal
005 Decreasing Sex and Gender Disparities in Health Outcomes: Minimal
006 Living Donor Protection Act of 2017 (HR 1270): Modest
007 Oppose the Criminalization of Self-Induced Abortion: Minimal
008 Health Care Rights of Pregnant Minors: Modest
009 Improving and Increasing Clarity and Consistency Among AMA Induced Abortion Policies: Minimal
010 Gender Equity in Compensation and Professional Advancement: not yet determined
011 Women Physician Workforce and Gender Gap in Earnings - Measures to Improve Equality: not yet determined
012 Costs to Kidney Donors: Modest
013 Opposing Surgical Sex Assignment of Infants with Differences of Sex Development: Minimal
014 Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms: not yet determined
015 Human Trafficking / Slavery Awareness: not yet determined
101 Medicaid Reform: Minimal
102 Effectiveness of Risk Assessment Models in Representing Healthcare Resources Expended for Infants and Children: Minimal
103 Oppose Medicaid Eligibility Lockout: Minimal
104 Emergency Out of Network Services: Modest
105 Use of High Molecular Weight Hyaluronic Acid: Minimal
106 Prohibit Retrospective ER Coverage Denial: Minimal
107 Opposition to Medicaid Work Requirement: Minimal
108 Expanding AMA's Position on Healthcare Reform Options: Minimal
109 Medicaid Coverage of Fitness Facility Memberships: Minimal
110 Return to Prudent Layperson Standard for Emergency Services: Minimal
111 Medicare Coverage for Dental Services: Modest
112 Enabling Attending Physicians to Waive the Three-midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs: Minimal
113 Survivorship Care Plans: not yet determined
SUMMARY OF FISCAL NOTES (A-18)

Resolution(s)
114 Inclusion of Bundled Payments Care Improvement (BPCI) Post-Acute only Model 3 in Advanced BPCI: Minimal
201 Removing Barriers to Obesity Treatment: Modest
202 Universal and Standardized Protocols for EHR Data Transition: Modest
203 Updating Federal Food Policy to Improve Nutrition and Health: Minimal
204 Opposition to Mandated Proficiency in EHR for Licensure: Minimal
205 Augmented Intelligence: Modest
206 Appropriate Use of Telehealth Services: Modest
207 Quality Improvement Requirements: Minimal
208 Prior Authorization Requirements for Post-Operative Opioids: Minimal
209 Substance Use Disorders During Pregnancy: Modest
210 Banning the Sale of Bump Stocks: Minimal
211 Clarification from U.S. Department of Justice Regarding Federal Enforcement of Medical Marijuana Laws: Modest
212 Value-Based Payment System: Modest
213 Utilization Review: Modest
214 Strengthening the Background Check System for Firearm Sales: Minimal
215 Regulation of Hospital Advertising: Modest
216 FDA Conflict of Interest: Minimal
217 Reforming the Orphan Drug Act: Minimal
218 Considering Feminine Hygiene Products as Medical Necessities: Minimal
219 Improving Medicare Patients’ Access to Kidney Transplantation: Modest
220 Ban on Semi-Automatic Assault Weapons and High Capacity Ammunition Magazines: Modest
221 Maintaining Validity and Comprehensiveness of U.S. Census Data: Minimal
222 Evidence Based Treatment in Substance Abuse Treatment Facilities: not yet determined
223 Treating Opioid Use Disorder in Hospitals: Modest
224 Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions: Minimal
225 Pharmacy Benefit Managers Impact on Patients: Est. cost of $160K to conduct survey of 1,000 MDs. Includes survey development, qualitative testing, fielding of survey and summary analysis. Anticipated costs reflect increased screening to find drug dispensing MD practices.
226 Model State Legislation for Routine Preventative Prostate Cancer Screening for Men Ages 55-69: Modest
227 An Optional National Prescription Drug Formulary: Modest
228 Medicare Quality Incentives: Modest
229 Green Card Backlog for Immigrant Doctors on H-1B Visa: Modest
230 Opposition to Funding Cuts for Programs that Impact the Health of Populations: Modest
231 Online Controlled Drugs: Modest
232 Recording Law Reform: Modest
233 Support for Reauthorization of the Supplemental Nutrition Assistance Program: Modest
234 Support for Primary Care Enhancement Act: Modest
235 Hospital Consolidation: Modest
236 Reducing MIPS Reporting Burden: Modest
237 Safe and Efficient E-Prescribing: Modest
238 Reform of Pharmaceutical Pricing: Negotiated Payment Schedules: Minimal
Resolution(s)
239  Treating Opioid Use Disorder in Hospitals: Modest
240  Treating Opioid Use Disorder in Treatment Facilities: not yet determined
241  Accuracy and Accountability of Physician Compensation Reporting by Drug and Device Companies: Minimal
242  Pharmacy Benefit Managers and Compounded Medications: Minimal
243  Report Health Care Provider Sex Crimes to Law Enforcement: Modest
244  Protecting Medical Trainees from Hazardous Exposure: Minimal
245  For-Profit Medical Schools or Colleges: Modest
246  Fellowship Start Date: Estimated cost to implement resolution is $34,000. Estimate includes staff costs for developing the survey, cleaning the dataset, and report writing.
247  Persons With Intellectual and Developmental Disabilities Designated as a Medically Underserved Population: Minimal
248  Standardization of Medical Licensing Time Limits Across States: Minimal
249  Sex and Gender Based Medicine: Modest
250  Healthcare Finance in the Medical School Curriculum: Modest
251  Foreign Trained IMGs Obtaining a U.S. License Without U.S. Residency: Minimal
252  Foreign Trained IMGs Competency-Based Specialty Exam Without U.S. Residency: Modest
253  U.S. Institutions With Restricted Medical Licensure: Modest
254  Opioid Education for New Trainees: Minimal
255  Suicide Awareness Training: Minimal
256  Financial Literacy for Medical Students and Residents: Minimal
257  Board Certification Changes Impact Access to Addiction Medicine Specialists: Minimal
258  Peer-Facilitated Intergroup Dialogue: Modest
259  End “Part 4 Improvement in Medical Practice” Requirement for ABMS MOC: Minimal
260  Danger from Bright Vehicle Headlights: Modest
261  Schools as Gun-Free Zones: Minimal
262  School Safety and Mental Health: Modest
263  Emphasizing the Human Papillomavirus Vaccines as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic: Minimal
264  Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data: Moderate
265  Support for Public Health Violence Prevention Programs: Minimal
266  Support for Research of Boxes for Babies’ Sleeping Environment: Minimal
267  Ending Money Bail to Decrease Burden on Lower Income Communities: Minimal
268  Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities: Modest
269  Opposition to Measures that Criminalize Homelessness: Modest
270  Reporting Child Abuse in Military Families: Minimal
271  Reducing the Use of Restrictive Housing in Prisoners with Mental Illness: Minimal
272  Improving Safety and Health Code Compliance in School Facilities: Minimal
273  Sex Education Materials for Students with Limited English Proficiency: Minimal
274  Reducing Gun Violence in America: Modest
275  Medical Respite Care for Homeless Adults: not yet determined
276  Reducing Disparities in Obstetric Outcomes, Maternal Morbidity, and Prenatal Care: not yet determined
277  A Guide for Best Health Practices for Seniors Living in Retirement Communities: Modest
278  Violence Prevention: Modest
Resolution(s)

420  Mandatory Influenza Vaccination Policies for Healthcare Workers: Minimal
421  Product Date Labels: Modest
422  School Drinking Water Quality Testing, Monitoring, and Maintenance: Modest
423  Grill Brush Warning: Modest
424  Rape and Sexual Abuse on College Campuses: Modest
425  Hospital Food Labeling: Minimal
501  Synthetic Cannabinoids: Minimal
502  Expedited Prescription CBD Drug Rescheduling: Modest
503  Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians: Minimal
504  Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprax): Minimal
505  Researching Drug Facilitated Sexual Assault Testing: Modest
506  Non-Therapeutic Gene Therapies: Modest
507  Opioid Treatment Programs Reporting to Prescription Monitoring Programs: Minimal
508  Reintroduction of Mitochondrial Donation in the United States: Minimal
509  Opposing the Classification of Cannabidiol as a Schedule 1 Drug: Minimal
510  Alcohol Use and Cancer: Minimal
511  Education for Recovering Patients on Opiate Use After Sobriety: Minimal
512  Physician and Patient Education About the Risk of Synthetic Cannabinoid Use: Minimal
513  Hand Sanitizer Effectiveness: Modest
514  Effects of Virtual Reality on Human Health: Minimal
515  Information Regarding Animal-Derived Medications: Minimal
516  Waste Incinerator Ban: Modest
517  Impact of Natural Disasters on Pharmaceutical Supply and Public Health: Modest
601  Creation of LGBTQ Health Specialty Section Council: no significant fiscal impact
602  Health Fitness Partnerships: Minimal
603  Eliminating Food Waste Through Recovery: Minimal
604  AMA Delegation Entitlements: not yet determined
701  Employed Physicians Bill of Rights: Minimal
702  Basic Practice Professional Standards of Physician Employment: Minimal
703  Economic Credentialing: Minimal
704  Non-Payment and Audit Takebacks by CMS: Modest
705  Modify the Clinical Laboratory Improvement Amendment of 1988: Minimal
706  Ensuring Medicare Coverage for Long Term Care: Modest
707  Health Plan Payment of Patient Cost-Sharing: Modest
708  Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission: Modest
709  Prior Authorization for Durable Medical Equipment: Modest
710  Code Status Through the Continuum of Care: Modest
711  Compensation for Pre-Authorization Requests: Modest
SUMMARY OF FISCAL NOTES (A-18)

Minimal - less than $1,000
Modest - between $1,000 - $5,000
Moderate - between $5,000 - $10,000
Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)
02 New Specialty Organizations Representation in the House of Delegates
13 Mergers of Secular and Religiously Affiliated Health Care Institutions and Their Impact on Patient Care and Access to Services
23 Healthcare as a Human Right
24 Appropriate Placement of Transgender Prisoners
25 Recognition of Physician Orders for Life Sustaining Treatment Forms
26 Revision of Researcher Certification and Institutional Review Board Protocols

CC&B Report(s)
01 CCB Sunset Review of 2008 House Policies

CEJA Report(s)
01 Competence, Self-Assessment and Self-Awareness
02 Mergers of Secular and Religiously Affiliated Health Care Institutions
03 Medical Tourism
04 Expanded Access to Investigational Therapies
05 Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician Assisted Suicide" and "Aid in Dying"
06 CEJA's Sunset Review of 2008 House Policies

Resolution(s)
001 Discriminatory Policies that Create Inequities in Health Care
002 FMLA-Equivalent for LGBT Workers
003 Proposing Consent for De-Identified Patient Information
004 Patient-Reported Outcomes in Gender Confirmation Surgery
005 Decreasing Sex and Gender Disparities in Health Outcomes
006 Living Donor Protection Act of 2017 (HR 1270)
007 Oppose the Criminalization of Self-Induced Abortion
008 Health Care Rights of Pregnant Minors
009 Improving and Increasing Clarity and Consistency Among AMA Induced Abortion Policies
010 Gender Equity in Compensation and Professional Advancement
011 Women Physician Workforce and Gender Gap in Earnings - Measures to Improve Equality
012 Costs to Kidney Donors
013 Opposing Surgical Sex Assignment of Infants with Differences of Sex Development
014 Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms
015 Human Trafficking / Slavery Awareness
The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Rhinologic Society, American Society for Reconstructive Microsurgery, American Society of Neuroimaging, North American Neuromodulation Society, and the North American Neuro-Ophthalmology Society for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

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

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

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


RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Rhinologic Society, American Society for Reconstructive Microsurgery, American Society of Neuroimaging, North American Neuromodulation Society, and the North American Neuro-Ophthalmology Society be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500
GUIDELINES FOR REPRESENTATION IN & ADMISSION TO
THE HOUSE OF DELEGATES:

National Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.

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

3) The organization must meet one of the following criteria:
   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4) The organization must be established and stable; therefore it must have been in existence for at least 5 years prior to submitting its application.

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

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

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

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

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

10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.
RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

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

2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.

3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

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

5. To provide information and data to the AMA when requested.
**Exhibit B - Summary Membership Information**

<table>
<thead>
<tr>
<th>Organization</th>
<th>AMA Membership of Organization’s Total Eligible Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Rhinologic Society</td>
<td>172 of 265 (65%)</td>
</tr>
<tr>
<td>American Society for Reconstructive Microsurgery</td>
<td>168 of 663 (25%)</td>
</tr>
<tr>
<td>American Society of Neuroimaging</td>
<td>105 of 280 (38%)</td>
</tr>
<tr>
<td>North American Neuromodulation Society</td>
<td>260 of 942 (28%)</td>
</tr>
<tr>
<td>North American Neuro-Ophthalmology Society</td>
<td>100 of 454 (22%)</td>
</tr>
</tbody>
</table>
Subject: Mergers of Secular and Religiously Affiliated Health Care Institutions and Their Impact on Patient Care and Access to Services

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Peter H. Rheinstein, MD, JD, MS, Chair)

Policy D-140.956, “Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient Centered, Safe Care Services,” asks that the American Medical Association (AMA):

- conduct a study of access to care in secular hospitals and religiously affiliated hospitals to include any impact on access to services of consolidation in secular hospital systems and religiously affiliated hospital systems.

AMA lacks the necessary research infrastructure to carry out an extensive empirical study regarding the impact of such mergers on patients’ access to care. This report reviews the best evidence currently available in this area from governmental agencies, academic institutions, and scholarly and popular publications. Council on Ethical and Judicial Affairs Report 2-A-18, “Mergers of Secular and Religiously Affiliated Health Care Institutions,” provides ethics guidance for physicians in this context.

BACKGROUND

The changing landscape of the American healthcare sector and evolving market forces have motivated health care institutions to consider mergers, acquisitions, partnerships, and other types of transactional relationships for the purpose of consolidation [1]. The economic recession from 2007 to 2009 and the passage of the 2010 Affordable Care Act (ACA) may have played a substantial role in driving mergers in recent years; 112 mergers were reported in 2015, compared to 105 in 2012 and 66 in 2010 [1,3]. With the ACA encouraging the creation of Accountable Care Organizations for coordinated care and new value-based payment models, health care institutions were encouraged to merge and create economies of scale to reduce expenses and share profits across larger patient volumes, standardize and streamline protocols to improve operational efficiency, and expand their scope of services and care networks to facilitate patient access [3–5].

RELIGIOUSLY AFFILIATED HEALTHCARE IN THE UNITED STATES

Secular and religiously affiliated institutions alike feel pressures to merge [6], in particular, small, independent, rural, and/or financially struggling hospitals [7]. Rural populations often face wide health disparities and lack of access to care, and over 2,000 rural hospitals struggle operationally and financially with low patient volume, provider shortages, and poor facilities and resources [8]. Since 2010, more than 60 rural hospitals have closed in 20 states, and several hundred more may be...
vulnerable to closure, especially in southern states [9]. Because of these issues, rural hospitals may be particularly susceptible to external and economic forces that lead them into merger transactions.

Religiously affiliated or faith-based health care institutions can include hospitals, clinics, and other centers of care partnered with, established by, owned by, and/or managed by a wide array of religious entities in the U.S., such as Catholic, Protestant (e.g., Methodist, Presbyterian, Baptist, Evangelical, Adventist), Mormon, and Jewish organizations. Catholic institutions are the most numerous, comprising over 600 hospitals and over 1,600 clinics and other care facilities [10]. Collectively, they serve as the nation’s largest group of nonprofit health care providers [10,11]. Catholic hospitals constitute nearly 15 percent of all acute care hospitals, treating about one-sixth of all acute care hospital patients, with 5 million admissions and 20 million emergency room visits a year [10]. Since 1997, over 140 mergers have occurred between non-Catholic and Catholic institutions [12]. From 2000 to 2016, the number of acute care hospitals with Catholic affiliations grew 22 percent, even as the overall number of acute care hospitals declined [11]. Ten of the 25 largest health systems are Catholic-affiliated [11]. An estimated 25 percent of Catholic hospitals and 15 percent of Catholic continuing care facilities are located in rural areas [10]. Out of over 1,300 Critical Access Hospitals (specially designated hospitals located in high-need rural areas), 132 are Catholic-affiliated [10,13]; as of 2016, 46 Catholic hospitals were the sole health providers for their communities [11].

Protestant and Jewish institutions also form a prominent part of the religiously affiliated healthcare sector. In the U.S., around 50 hospitals and health systems are affiliated with the United Methodist Church; the Adventist Health System manages 46 facilities; and close to 20 Jewish hospitals are in operation; accurate figures are difficult to find for the numbers of Presbyterian, Baptist, Mormon, or other health care institutions [14,15,16].

THE IMPACT OF MERGERS ON PATIENT CARE

Evidence about the impact of mergers between secular and religiously affiliated institutions is limited and largely anecdotal in nature. Much of our knowledge of these issues is derived from news articles and reports from advocacy organizations such as the American Civil Liberties Union (ACLU) and MergerWatch.

Based on what evidence we have the effects on clinical services and care of mergers that involve non-Catholic religiously affiliated institutions appear to be diverse. For example, some Baptist, Adventist, and Mormon institutions are opposed to abortions in accordance with their principles [1,2]; other merged entities, such as Missouri’s Barnes-Jewish Hospital, and the Protestant-affiliated Advocate Health Care in Illinois do provide abortions [17,18,19]. (An institution’s faith tradition may shape nonclinical aspects of patient experience, as when Jewish hospitals observe Shabbat and Jewish holidays, display ritual objects, provide kosher meals, or designate kitchens for Orthodox patients [20]. Similarly, at least one Adventist institution declines to serve nonvegetarian food or any stimulants [21,22].)

Not surprisingly given the prominence of Catholic institutions in U.S. health care, the published material focuses heavily on mergers that involve Catholic organizations, which are governed by the Ethical and Religious Directives for Catholic Health Services (ERDs) issued by the U.S. Conference of Catholic Bishops [23]. The ERDs address many aspects of institutional life in Catholic and Catholic-affiliated facilities, providing directives not only regarding the services available to patients, but also directives to guide partnerships between Catholic and non-Catholic health care institutions [23]. Other faith-based health care organizations do not have a comparable
body of detailed formal directives, though the websites of faith-based health systems or individual facilities generally state the institution’s core values.

Religious Directives for Catholic Health Services

The Catholic Health Association of the United States (CHA) identifies its member institutions as ministries of the Catholic Church [24]. In line with the religious values of the Church and the guidance of the ERDs, Catholic institutions often restrict the provision of certain health services, particularly in reproductive care [11,23]. The ERDs state that “abortion…is never permitted,” although “operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable” [23]. Additionally, Catholic institutions “may not promote or condone contraceptive practices,” and “direct sterilization of either men or women, whether permanent or temporary, is not permitted” [23].

Reproductive Health Services. Women have been denied a wide range of reproductive services at Catholic hospitals, even when there may be substantial risk to the woman’s health or life of the patient [25–28]. Women with nonviable pregnancies have reportedly been turned away from Catholic hospitals until severe hemorrhaging or infection occurs [29]. In other cases, patients who request tubal ligations to be performed at the same time as a C-section are refused this service, even if future pregnancies are risky [29]. Obstetrician-gynecologists have also reported feeling unduly constrained by Catholic hospital administrators when exercising their clinical judgment in managing miscarriage, nonviable pregnancies, and serious maternal complications [30–32]; in one sample, 52 percent of obstetricians-gynecologists in Catholic institutions reported experiencing conflict with their hospital’s religious policies [32].

In 2010 in rural Arizona, the secular Sierra Vista Regional Health Center became affiliated with the Catholic-based Carondelet Health Network and adopted the ERDs to guide its clinical services [25]. In one incident at Sierra Vista, a physician is reported to have recommended termination of pregnancy to a woman who had miscarried one of her twins and faced a low chance of the other twin’s survival and high risk of hemorrhage and infection. A hospital administrator denied the procedure; however, and the patient was instead driven by ambulance to a hospital 80 miles away for treatment. After the incident, Sierra Vista broke their relationship with Carondelet after one year of a two-year trial period and chose to affiliate with a secular network instead.

Patients have also reported being unaware that the services they want will not be provided until they have already arrived at a Catholic hospital or begun treatment, and religious facilities can be unwilling to refer patients elsewhere [26,29].

This is not to say that Catholic facilities always adhere strictly or uniformly to the ERDs. For example, under the ERDs, men could also be refused many reproductive services, including contraception, sterilization, and participation in decisions on prenatal diagnosis and artificial insemination [23]; however, at least one Catholic health system, Ascension Health, performs vasectomies for men but not tubal ligations for women [33]. In 2010, Sister Margaret McBride, an administrator at a Catholic Healthcare West hospital in Arizona, authorized the termination of a pregnancy due to the high risk of mortality for both mother and child [33]. Although both the CHA and the hospital supported McBride’s decision, the local diocesan bishop later excommunicated McBride and stripped the hospital of its Catholic affiliation, causing controversy in the Catholic health community [34].
Services for Transgender Patients. The CHA does not specifically deny services on the basis of sexual orientation. In January 2018, Sister Carol Keehan, president and CEO of the CHA, stated that “any services [that Catholic institutions] offer are available to everybody,” elaborating that “transgender patients have heart attacks … and gallbladder surgery” and that “[Catholic hospitals] have delivered many a lesbian couple’s baby and many a gay couple’s baby” [35]. The Human Rights Campaign’s Healthcare Equality Index evaluates nearly 600 American hospitals on the basis of their care, services, and policies relating to LGBTQ individuals and has previously rated several Bon Secours hospitals, which are members of the CHA, with moderate to high scores [36].

However, Catholic institutions have refused to perform gender-affirming surgery in the past; in one example, Franciscan Health in Indiana sued the Obama administration over a gender identity nondiscrimination rule mandated by the ACA [37]. The National Catholic Bioethics Center believes that “no Catholic health care organization should require its personnel to carry out, promote, refer for, or otherwise cooperate formally in procedures involved in gender transitioning, especially surgical or hormonal intervention” [38]. In 2017, the CHA’s senior director of ethics and theology stated, “For most medical providers the issue is settled in terms of seeing gender dysphoria as something that can be treated legitimately…[but] Catholic ethicists still have many questions about its moral permissibility” [39]. There have been media reports of instances in which transgender patients have been denied hysterectomies under the ERD restriction on sterilization [40,41] and mastectomies [42–44].

Physician-Assisted Suicide. In U.S. jurisdictions that have legalized physician-assisted suicide—as of March 2018, California, Colorado, the District of Columbia, Hawaii, Montana, Oregon, Vermont, and Washington—access to legally permitted “aid in dying” is unlikely to be available from religiously affiliated institutions and clearly will not be from Catholic-affiliated institutions. In guidance on care for patients who are seriously ill or dying, the ERDs unequivocally prohibit intentionally hastening death, stating “Suicide and euthanasia are never morally acceptable options” [23]. The ERDs provide that “Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way” [23].

The possible impact of these or similar restrictions is difficult to estimate, but reports indicate that the ERDs have had an effect in jurisdictions where physician-assisted suicide is legal. For example, in Washington state in 2010, the Catholic-affiliated PeaceHealth merged with the Clark County public hospital, which then stopped referring patients for PAS-related counseling [45]. In 2013, physicians at Harrison Medical Center in Bremerton, Washington, were restricted from prescribing medications for assisted suicide after Harrison affiliated with the Catholic-based Franciscan Health System [46]. As of 2012, some 30 percent of hospital beds in Washington were owned by Catholic institutions [47].

Effects on Health Plans

There is also evidence to suggest that mergers among secular and religiously affiliated health care institutions can affect the terms of health insurance plans. In 2017 in northwestern Indiana, for example, a proposed merger between a Catholic-affiliated Franciscan system and Methodist Hospitals would have left only one non-Catholic hospital in the county [37]. This hospital would not be included in the network of the only insurer offering plans for the region on the ACA exchange, in effect making Franciscan Health and Catholic hospitals exclusive providers for this plan. This may have forced patients on this plan to travel out of their network to receive services not provided by in-network facilities [37]. Some large Catholic health systems, such as Catholic Health Initiatives and Ascension Health, have also expressed interest in offering their own health insurance plans as they have expanded their merged systems [37]. Catholic institutions attaining
exclusive provider status with insurance plans, especially those offered by employers or on
subsidized ACA exchanges, could create serious concerns for patient access to care.

CONCLUSION

Although there has been limited scholarly research regarding the clinical impact specifically of
mergers among secular and religiously affiliated health care institutions, this literature suggests that
patients may have more difficulty gaining access to some services as a result of such mergers. A
growing body of anecdotal evidence in the form of media reports describing cases in which these
mergers appear to have affected care for individual patients argues to a similar conclusion, as do
efforts to monitor the impact of mergers among advocacy organizations.

RECOMMENDATION

Your Board of Trustees concludes that the foregoing fulfills Directive D-140.956, “Religiously
Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient Centered,
Safe Care Services,” and recommends that the directive be rescinded and the remainder of this
report be filed. (Directive to take Action)

Fiscal Note: Less than $500
REFERENCES


INTRODUCTION

At the 2017 Annual Meeting, the House of Delegates referred Resolution 7-A-17, “Health Care as a Human Right.” This resolution was introduced by the Minority Affairs Section and asked that our AMA:

1. recognize that a basic level of health care is a fundamental human right;
2. support the United Nations’ Universal Declaration of Human Rights and its encompassing International Bill of Rights as guiding principles fundamental to the betterment of public health; and
3. advocate for the United States to remain a member of the World Health Organization.

HEALTH CARE AS A HUMAN RIGHT

Human rights are ethical demands that create duty to safeguard underlying freedoms of significant social importance.1 This duty may be legal, e.g., through statute or international treaty, or moral in its foundation. Depending on context, human rights can be thought of as legal, philosophical, or sometimes aspirational.2 All these concepts of human rights are interrelated; indeed, human rights are conceived through ethical reasoning drawing on experience, beliefs, and theories of justice.

The philosophical underpinning of creating an ethical human right is largely that of justice, which may be described as fairness in equitable distribution of primary social goods3 such as liberty, opportunity, and income. From this concept of fairness comes the ethical demand to create a human right, which may then be extended to health care, because by keeping people healthy, people’s ability to participate in political, social, and economic life is promoted and preserved.4 A right to health care does not give individuals a basic right either to be healthy or to have all their health care needs met.

However, a right to health care will broadly encompass access to care.5 Access means that health care facilities, goods, and services must be available to everyone in [a defined] jurisdiction without discrimination, [and must be] affordable, physically accessible, and within a reasonable distance for all people.5 If people are denied access to a basic level of services adequate to protect normal functioning, an injustice is done to them. Indeed, the concept of accessibility as a core principle of human rights to health care is widely recognized and supported.
Although it does not directly support a “right to health care,” Principle IX of the AMA Principles of Medical Ethics states: “A physician shall support access to medical care for all people.” Equitable access to medical care is a core component of the right to health care, and Opinion 11.1.1, of the Code of Medical Ethics, “Defining Basic Health Care,” is derived from this principle. The Opinion maintains that health care is “a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. Society has an obligation to make access to an adequate level of care available to all its members, regardless of ability to pay.” Further, Opinion 11.1.4, “Financial Barriers to Health Care Access,” explains: “As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.”

Other policies of the AMA House of Delegates also support access to healthcare. For example, it is AMA policy that “no one shall be denied necessary medical care because of inability to pay for that care” (Policy H-160.987, “Access to Medical Care”). Policy H-160.975, “Planning and Delivery of Health Care Services,” explains that “both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing shortcomings in the current public system for providing access need to be addressed.”

SUPPORTING THE UNITED NATIONS’ DECLARATION OF HUMAN RIGHTS AND THE WORLD HEALTH ORGANIZATION

Resolution 7-A-17 also asks that our AMA support the United Nations’ Universal Declaration of Human Rights and the International Bill of Rights as guiding principles fundamental to the betterment of public health. The Declaration consists of 30 articles affirming an individual’s rights that, although not legally binding in themselves, have been elaborated in subsequent international treaties, economic transfers, regional human rights instruments, national constitutions, and other laws. The Declaration was the first step in the process of formulating the International Bill of Human Rights, which was completed in 1966, and came into force in 1976.

The United Nations (UN) is an intergovernmental organization made up of 193 member nations. The World Health Organization (WHO) is the directing and coordinating authority on international health within the UN system. The objective of WHO is the attainment by all peoples of the highest possible level of health. Governance takes place through the World Health Assembly (WHA), which is made up of representatives from the health ministries of these national governments, and is the supreme decision-making body. The Executive Board gives effect to the decisions and policies of the Health Assembly. The organization is headed by the Director-General, who is appointed by the WHA on the nomination of the Executive Board. The WHO collaborates with the UN system to position health in the debates and decisions of UN intergovernmental bodies; contributes to a coherent and effective UN system at global, regional, and country levels; provides leadership in health-related humanitarian efforts, and promotes alliances and interagency approaches to address health issues.

By contrast, the WMA is a non-governmental international organization representing physicians. The organization was created to ensure the independence of physicians and to work for the highest possible standards of ethical behavior and care by physicians at all times. The AMA is a founding member of the WMA, which has always been an independent confederation of free professional
associations and has grown to include 114 national medical association members. Our main role at
the WMA is to develop policy and advocacy agendas in line with AMA policies.

The WMA is in “Official Relations” with the WHO and seeks to advise and influence the work of
this intergovernmental body. WMA’s cooperation with the WHO is very broad and covers nearly
all areas of medicine and health. As a commitment to our international interests, AMA officers
have regularly attended the WHA, either as non-governmental advisors to the United States
Delegation or as Delegates to the Assembly from the WMA.

AMA Policy H-250.986, “AMA and Public Health in Developing Countries,” outlines a
circumscribed strategy for AMA participation in international policy and advocacy issues mainly
by our involvement in the WMA and, to a lesser degree, in our advisory capacity at the WHA. For
this and other reasons, our AMA does not take positions on treaties, such as the United Nations’
Universal Declaration of Human Rights, but works through established channels to effect
supportable outcomes.

In addition, AMA Policy H-250.999, “World Health Organization,” expresses AMA’s direct
support of the WHO as an institution and the United States’ involvement with it; this support is
ongoing. AMA Policy H-250.992, “World Health Organization,” affirms support for the WHO and
urges the United States to provide full funding for the organization. This policy also encourages the
WMA to develop cooperative work plans with the WHO.

CONCLUSION

The Board of Trustees appreciates that Resolution 7-A-17 expresses the desire to ensure that all
people have access to a basic level of health care. Our AMA has long advocated for equitable
access to health care through policy, advocacy, and a targeted strategy of active international
policymaking through the WMA and the WHO. The Board of Trustees believes that existing policy
adequately supports that intention.

RECOMMENDATION

The Board of Trustees therefore recommends that AMA Policies H-160.987, “Access to Medical
Care;” H-160.975, “Planning and Delivery of Health Care Services;” H-250.986, “AMA and
Public Health in Developing Countries;” H-250.992, “World Health Organization;” and
H-250.999, “World Health Organization,” be reaffirmed in lieu of Resolution 7-A-17 and that the
remainder of the report be filed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500

REFERENCES

2 Gostin LO. Public Health, Ethics, and Human Rights: A tribute to the late Jonathan Mann. The Journal of
Law, Medicine & Ethics. 2001; 29:121-130.
5 Kinney ED. The International Human Right to Health: What Does This Mean for our Nation and World?
6 McGill M, MacNaughton G. The Struggle to Achieve the Human Right to Health Care in the United States.
Subject: Appropriate Placement of Transgender Prisoners (Resolution 15-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Peter H. Rheinstein, MD, JD, MS, Chair)

At the 2017 Annual Meeting the AMA House of Delegates referred Resolution 15-A-17, “Appropriate Placement of Transgender Prisoners,” from the New England delegation, which asked:

That our American Medical Association establish policy supporting the ability of transgender prisoners to be placed in facilities that are reflective of their affirmed gender status regardless of surgical status, if they so choose.

The Reference Committee on Amendments to Constitution and Bylaws noted that testimony was evenly divided in support of the resolution and ultimately recommended referral, recognizing the “complexities of this issue” and “that more information and research on the subject are necessary.” In response, this report identifies and addresses concerns relevant to the placement of transgender prisoners.

BACKGROUND

The problem facing the safety and health of transgender prisoners is severe and well documented. Transgender prisoners are disproportionately the victims of sexual assault, suffering higher rates of sexual assault than general population inmates [1,2]. The increased rate of violence largely stems from transgender prisoners being housed based on their birth sex, and not according to their affirmed gender [1]. One study showed that birth sex-based housing policy has allowed transgender prisoners to suffer from rape, harassment, and physical violence at a rate of 34 percent compared to 10 percent for the overall population [3]. Another study, of only California prisons, has shown that 59 percent of transgender prisoners experience sexual assault, versus only 4.4 percent of the overall prison population [4], with another study showing that the proportion of transgender prisoners in California experiencing sexual assault to be as high as 75 percent [1].

The risks of violence typically are in the context of transfeminine inmates, because “of animosity toward the expression of their gender identity and because many have slight and effeminate builds” [5]. Genitalia-based prison housing policies place transgender inmates at special risk of sexual violence, because the “prison hierarchy subjugates the weak to the strong and equates femininity with weakness” [6].

GENITALIA/BIRTH SEX-BASED HOUSING POLICY

The status quo of most prisons and jails in the United States is to house transgender prisoners according to their birth/biological sex and not according to their affirmed gender identity [7].
Genitalia based housing policy is “deeply ingrained” in the United States to the point where it is taken for granted without any official justification [8]. This status quo is founded on a limited definition of “transgender” constrained to the “gender binary,” a social construct where only two genders are recognized at birth: male or female [7,9]. A more useful definition of “transgender,” one that breaks free of the “gender binary,” is a person “whose inner gender identity and outward gender expression differ from the physical characteristics of the body at birth” [10].

Under the status quo, many correctional institutions try to ameliorate the risks and hazards of sex-based housing by placing transgender prisoners in administrative segregation. Such segregation, in the interests of safety, isolates transgender prisoners from the general population [1]. However, administrative segregation is not a good solution as it creates its own sets of problems. It often differs little from punitive segregation or solitary confinement. Such confinement removes prisoners from the companionship of others, denies prisoners access to prison programs, and is psychologically damaging [7]. Administrative segregation acts as a further punishment of the transgender prisoner and has been significantly criticized by scholars and attorneys [2].

ALTERNATIVE HOUSING POLICIES

In an attempt to address health and safety problems of transgender prisoners several jurisdictions have created alternative jail housing policies based on “the sex the individual identifies with and where they will be the safest, as opposed to genitalia-based placement” [9].

For example, in 2002 San Francisco County, California, instituted a protocol that requires jail officials to assess transgender prisoners for vulnerability and place vulnerable individuals in a unit with other vulnerable populations, away from “predators;” the policy has resulted in marked decreases in sexual assaults [2]. In 2009 the Washington, DC, Department of Corrections similarly enacted a housing policy that takes into account the opinions of transgender individuals and healthcare professionals and permits inmates to be housed according to their gender identity [9,11]. In 2011 Cook County, Illinois, likewise changed its policy to allow transgender inmates to “be housed, dressed, and searched according to their gender identity rather than the sex/gender they were assigned at birth” [9].

AMA POLICY

Several AMA policies address a range of transgender issues [12,13,14]. House Policy H-65.964, “Access to Basic Human Services for Transgender Individuals,” opposes policies that prevent transgender individuals from accessing services and facilities (including restrooms) in line with one’s gender identity [12]. House Policy H-65.967, “Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients,” supports policies that allow for a change of sex designation on a birth certificate for transgender individuals, whether or not an individual has undergone surgery [13]. House Policy H-40.966, “Military Medical Policies Affecting Transgender Individuals,” affirms that there is no medical reason to prohibit transgender individuals from serving in the military [14].
RECOMMENDATION

In consideration of evidence indicating the risk placement choices pose for transgender prisoners, the Board of Trustees recommends that the following be adopted in lieu of Resolution 15-A-17 and the remainder of this report be filed:

1. That our American Medical Association supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner’s genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status; and (New HOD Policy)

2. That our American Medical Association supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement. (New HOD Policy)

Fiscal note: Less than $500
REFERENCES

Subject: Recognition of Physician Orders for Life Sustaining Treatment (POLST) Forms
(Resolution 20-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Peter H. Rheinstein, MD, JD, MS, Chair)

At the 2017 Annual Meeting, the House of Delegates referred Resolution 20-A-17, “Recognition of Physician Orders for Life Sustaining Treatment (POLST) Forms,” introduced by the Organized Medical Staff Section, which asked:

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; and

That our AMA create a universal Physician Orders for Life Sustaining Treatment form that would be valid and enforceable in all states.

The reference committee heard testimony unanimously in support of the intent of the resolution. Testimony highlighted the challenges of respecting the medical care orders of patients when they cross jurisdictional boundaries. However, testimony also emphasized that a universal POLST form may be impractical because POLST is one of many end-of-life care frameworks in use in the United States.

The reference committee agreed that reciprocity of physician orders between states is important, but noted myriad problems with a universal POLST form. The Reference Committee suggested that “model state legislation be crafted in order for [reciprocity] to be accomplished in a way that can realistically be implemented” and referred the resolution. This Board Report provides background and discussion of interstate recognition of POLST and provides a recommendation.

BACKGROUND

Physician Orders for Life Sustaining Treatment were created in the 1990s in the state of Oregon in response to concerns that Do Not Resuscitate Orders (DNRO) had certain inadequacies; chief among them was their inability to transfer to other facilities (nursing homes, hospitals, hospice, ER’s, etc.) as the patient moved [1,2]. POLST was created to improve “end-of-life care by overcoming many of the advance directives’ limitations. It is designed to convert patient preferences for life-sustaining treatment into immediately actionable medical orders” that then “can be followed by medical personnel regardless of the patient’s location” [3,4]. POLST has largely been successful, with studies showing greater effectiveness in care “delivered in accordance with patient wishes” and recent years have seen increased adoption of the program in states around the country [5]. POLST is increasingly becoming established, alongside advance directives, as an important end-of-life decision making tool.
However, a problem has emerged with the recognition of POLST as patients cross state lines. There is a lack of uniformity in how states recognize a POLST from other states. This creates uncertainty if a POLST originating in one state will be followed in another state. This uncertainty risks the proper adherence of a patient’s desires regarding life-sustaining treatment as they travel from one state to another.

STATE LAW

To be effective, a POLST program must be universally recognized and honored. While POLST in each state aims to achieve the same goal of honoring patient wishes during a medical crisis, each state has its own requirements and procedures for a valid POLST.

POLST currently exists at some level in all 50 states and Washington, DC. Sixteen states explicitly recognize out-of-state POLST: Colorado, Delaware, the District of Columbia, Georgia, Idaho, Illinois, Iowa, Maryland, Nevada, New Jersey, New York, Oregon, Rhode Island, Utah, Vermont and West Virginia. Only one state expressly limits reciprocity. In Oklahoma, an out-of-state form is only valid for 10 days after patient’s admission into an Oklahoma medical facility. In states with statutes that are silent on reciprocity, accepted medical practice or custom may allow recognition of an out-of-state POLST absent statutory guidance.

There are four main statutory approaches taken to POLST reciprocity: states may honor a POLST if it complies with the originating state’s requirements, if it complies with the receiving state’s requirements, if it reasonably satisfies the receiving state’s requirements or if it complies with either the originating or receiving state’s requirements. State laws vary on approach.

ETHICAL ISSUES

The scope of Resolution 20-A-17 is focused on the portability of POLST across state lines. In this context, significantly relevant is the ethical force of autonomy in end-of-life decision making and how it is central to continual support of POLST. “The POLST process increases the likelihood that each person will receive the desired care and not receive undesired care” [2]. Indeed, studies have also shown POLST to be successful in the “honoring of patient preferences” [8]. The fundamental ethical principle of patient autonomy (the driving force behind POLST) is the reason why, despite ethical shortcomings that exist with any end-of-life decision making model, POLST remains a durable clinical decision making tool. Therefore, there is ethical impetus to see greater portability of POLST across states lines, as the more likely a POLST from one state is enforced and recognized by another state, the greater likelihood that a patient’s autonomy at the end-of-life will be respected.

RELEVANT AMA POLICIES

End-of-life decision making is a significant issue in the medical profession and in the field of bioethics. As such, the AMA is strongly supportive of the concept and has published its support for such measures. For example, Chapter 5 of the *Code of Medical Ethics* focuses on caring for patients at the end of life. This chapter of the *Code* has several opinions supporting the concept of advance care planning and withholding life-sustaining treatment [9,10,11,12]. The *Code* explains that “advance care planning is widely recognized as a way to support patient self-determination” and that a patient “has the right to decline any medical intervention or ask that an intervention be stopped, even when that decision is expected to lead to his or her death” [9,11].
The AMA has additionally shown its support for end-of-life decision making through numerous House Policies and Directives [13,14,15,16,17,18]. Policies have called for the AMA to encourage people to establish advance directives and explain that advance directives “are the best insurance for individuals that their interests will be promoted in the event they become incompetent” [13,14]. Also, the AMA has adopted a directive to endorse “The Uniform Health-Care Decisions Act,” a uniform law designed to help govern, simplify, and standardize advance directives [18]. AMA policy does not address issues of reciprocity across jurisdictions.

DISCUSSION

Resolution 20-A-17 would instruct the AMA to create a universal POLST form. Drafting a universal POLST form is fraught with challenges as different jurisdictions have different hierarchies, rules and statutes with regards to end-of-life care. A universal form will not work across all states, as some states may not be able to adopt such a form.

The reference committee’s recommendation to create model legislation that would enable POLST reciprocity between the states is a more workable solution. This approach was recognized by the National POLST Paradigm Task Force (NPPTF) legislative group. The group, an assembly of health law experts tasked with providing perspectives to POLST legal issues, offered solutions, among other things, to the problem of POLST portability across state lines. The group recommended the adoption of a “uniform law” that would offer reciprocity of POLST across state lines. The NPPTF legislative group notes:

While it is still under revision and not directly applicable to POLST, one potential source of guidance is the draft Inter-jurisdictional Recognition of Substitute Decision-Making Documents Act from the National Conference of Commissioners on Uniform States Laws [19]. If adapted to POLST, the reciprocity provisions in this Act would deem a POLST form valid if, when completed, it complied with the law of the jurisdiction where it was completed [7].

However, a uniform law from the National Conference of Commissioners on Uniform State Laws specifically with regards to POLST is not yet in existence and remains a theoretical solution to the problem of POLST portability. Until such uniform law is available for consideration, states may elect to enact legislation establishing reciprocity to address current problems with POLST compliance across jurisdictions.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 20-A-17, and that the remainder of this report be filed:

1. That our American Medical Association work with state medical associations to advocate with appropriate legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment forms completed in one state as valid and enforceable in other states; (Directive to Take Action) and

2. That our AMA draft model state legislation that will allow for reciprocity of POLST forms. (Directive to Take Action)

Fiscal Note: Modest—Between $1,000 and $5,000
REFERENCES


6. Okla. State 63 § 3105.3.


Subject: Revision of Researcher Certification and Institutional Review Board (IRB) Protocols (Resolution 11-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Peter H. Rheinstein, MD, JD, MS, Chair)

Resolution 11-A-17, “Revision of Researcher Certification and Institutional Review Board (IRB) Protocols,” sponsored by the Florida Delegation, was referred by the House of Delegates in June 2017. This resolution asks our AMA to:

- Study existing Collaborative Institutional Training Initiative standards, Institutional Review Board protocols and create recommendations that would simultaneously protect patients and permit physicians to easily participate in the dissemination of medical knowledge.

HUMAN SUBJECTS PROTECTIONS

Concerns about the ethical conduct of research involving human participants date back to the 19th century, well before the evolution of the current regulatory framework in the U.S. [1]. The principles underlying the current system of oversight of human subjects protections were set out in the 1979 Belmont Report by the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research [2], and subsequently codified in regulations adopted by the Department of Health and Human Services (DHHS) and by 14 departments and agencies a decade later—the “Common Rule” [3]. The Common Rule sets basic standards for research oversight, including the establishment of institutional review boards (IRBs) and review procedures, and criteria for individual informed consent [4]. The goal of this—and similar regulatory efforts in other countries—is to protect the rights and well-being of individuals who participate as subjects in biomedical and behavioral research.

The Common Rule has been criticized as ineffective, cumbersome, and of questionable value in actually protecting research participants [5-7]. A 2011 review of empirical studies indicated, for example, that there is considerable variation in IRB structure, membership, processes, and in outcomes of IRB reviews [6]. A recent study of whether and how essential elements of human subjects protection are implemented during institutional review or research protocols found considerable variation among 20 participating IRBs [8]. The current system of oversight has also been critiqued as unable to address effectively the challenges of today’s research landscape, especially in light of the increasing prominence of multi-site research involving large numbers of participants and research involving large data sets or collections of biospecimens, and their implications for informed consent [9].

In 2011, the DHHS launched a review and reassessment of the Common Rule, issuing an Advanced Notice of Proposed Rule Making (ANPRM) seeking public comment to enhance protection of research subjects and improve the process of research review [10].
Four years later, DHHS issued a Notice of Proposed Rule Making (NPRM) soliciting comment on proposed updated policy. Stakeholders opposed the NPRM’s proposal to require consent for secondary research use of unidentified biospecimens, but supported proposals for improving informed consent, especially for simplifying consent forms while suggesting some modifications, which are reflected in the Final Rule issued in January 2017 [11-12]. The Final Rule also retains provisions intended to reduce unnecessary regulation and streamline oversight processes, including creating new categories of exemption from IRB review for low-risk studies, eliminating the requirement of continuing review for some categories of research, and introducing new options for facilitating screening of prospective participants. (On January 19, 2018, DHHS issued notice that it would delay the compliance deadline for the updated Common Rule to July 19, 2018 [13].)

In 2008 and 2009, AMA shared its concern that over interpretation of Common Rule protections in the context of quality improvement activities imposed unnecessary regulatory burdens on important research [14-16]. AMA also provided input under the auspices of the Advanced Notice of Proposed Rule Making [17] and the Notice of Proposed Rule Making [18].

EDUCATING THE RESEARCH COMMUNITY ABOUT HUMAN SUBJECTS PROTECTIONS

The National Institutes of Health requires that “key personnel” on NIH-funded research involving human subjects receive education on protecting human subjects [19]. These include principal investigators and all other individuals who are responsible for the design or conduct of the research, including foreign awardees or foreign subcontractors and third party personnel or consultants, even if they are not compensated through the NIH award, as well as investigators involved in research that is exempt from IRB review. Investigators in research with human specimens, tissues, or data that has been determined not to involve human subjects in keeping with guidance from the Office for Human Research Protections (OHRP) are not required to fulfill the educational requirement, nor are personnel who are not involved in the design and conduct of human subject research. NIH leaves the decision of what educational programs to use to meet this requirement to investigators’ home institutions. The NIH Clinical Center offers free online education that institutions may elect to meet the education requirement.

In addition, the Collaborative Institutional Training Initiative (CITI) offers web-based education in human subjects protections developed by experts in research ethics, ethics committee process, and web-enabled learning [20-21]. Initially created in 2000 in response to the then newly announced NIH education requirement for agency grantees, CITI’s offerings have expanded over time to encompass a robust catalogue of instruction in multiple aspects of the responsible conduct of research. Modules are available to learners through institutional subscriptions (at a current cost of $3,400/year) or for purchase by individuals (“independent learners”) (currently $130/module).

Training is also available specifically for IRB members. OHRP, for example, offers periodic workshops on various topics in human subjects protections and has developed extensive policy guidance. It also offers practical tools to clarify interpretation of the Common Rule and help IRBs evaluate research protocols effectively; for example, decision charts to help IRBs answer such key questions as whether a proposed study involves human subjects, whether it is exempt from IRB review (or eligible for expedited review), or whether informed consent may be waived. Educational resources for IRBs are also available through organizations such as Public Responsibility in Medicine and Research (PRiMR), which offers certification for IRB professionals [5].

Although there are reservations about their effectiveness in meaningfully protecting human subjects, efforts have also been launched to accredit IRBs. Thus the Association for the
Accreditation of Human Research Protection Programs (AAHRPP) promotes quality standards and performance improvement for IRBs and institutional human research protection programs [6].

INSTITUTIONAL AND JOURNAL POLICIES

Institutions that carry out federally funded research, as well as professional journals that publish the findings of research with human subjects have similarly established expectations that research personnel will adhere to human subjects protections in keeping with federal regulations. For example, the University of Illinois at Champaign Urbana requires that researchers complete CITI’s “Core Basic Training for either social/behavioral research or biomedical research,” and more specialized modules as may be needed for the purposes of specific studies, such as those involving children [22]. The University of California-Berkeley likewise requires that faculty, students, and staff engaged in human subjects research complete appropriate CITI [23], while San Francisco State University requires “all researchers using research volunteers to pass an online research training course,” and provides links to both NIH and CITI courses [24]. Other institutions—e.g., Vanderbilt University School of Medicine [25], Duke University School of Medicine [26] —require completion of in-person courses or other educational programs developed by the institution to address NIH educational requirements for research carried out with human subjects.

Professional journals frequently require that authors reporting findings of social/behavioral or biomedical research with human subjects attest that the study presented adhered to human subjects protections and appropriate oversight. The International Committee of Medical Journal Editors (ICMJE) recommends that investigators ensure that “the planning, conduct, and reporting of human research” is in accord with the Declaration of Helsinki, the international statement of research ethics promulgated by the World Medical Association [27]. The Journal of the American Medical Association and JAMA Network journals, for example, require that authors of manuscripts reporting studies that involve human participants or animals submit documentation demonstrating formal review and approval (or waiver) of the research and describe the review and its determination [28]. Annals of Internal Medicine likewise requires authors to confirm appropriate review or affirm that the research reported is consistent with the principles of the Declaration of Helsinki [29], while The Lancet advises prospective contributors that it adheres to the ICMJE Recommendations [30].

AMA POLICY


CONCLUSION

Oversight of research that involves human participants must balance important interests of science, the community, and individuals. Commitment to protecting the well-being and rights of individuals who agree to participate in research is fundamental to the ethics of the medical profession and to public trust.
Significant attention has been given in recent years to enhancing the system of research oversight in ways that sustain robust protections for human participants while streamlining processes of review and oversight and minimizing the burden on investigators. As scholars recently noted in relation to the Common Rule, “In an age of big data and cybersecurity threats, and as new technologies reveal personal identities, ethics rules become even more important. Federal oversight will remain the bulwark against unethical practices. In the end, treating human research participants with respect and fairly is essential for continuing public support of vital scientific investigations” [31].

RECOMMENDATION

In light of the importance of protecting the well-being and rights of research participants and the considerations reviewed above, your Board of Trustees recommends that the following be adopted in lieu of Resolution 11-A-17, “Revision of Researcher Certification and Institutional Review Board (IRB) Protocols,” and the remainder of the report be filed:

That our AMA continue to support efforts to improve protections for human subjects of biomedical and behavioral research and advocate for change as opportunities arise. (New HOD Policy)

Fiscal Note: Less than $250
REFERENCES

14. Edward L. Langston, MD, Chair to Samuel Tilden, MD, JD, LLM, Chair, Secretary’s Advisory Committee on Human Research Protections. January 18, 2008.
17. James L. Madara, MD, EVP to Jerry Menikoff, MD, JD, Director, Office for Human Research Protections, October 26, 2011.
18. James L. Madara, MD, EVP to Jerry Menikoff, MD, JD, Director, Office for Human Research Protections, January 5, 2016.
At its 1984 Interim Meeting, the House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110, “Sunset Mechanism for AMA Policy”). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2012 Annual Meeting, the House amended Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following:

- As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
- In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset. (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification. (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.
- Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.
- The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice.
In this report, the Council on Constitution and Bylaws presents its recommendations on the disposition of the House policies from 2008 that were assigned to it. The Council’s recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Council on Constitution and Bylaws recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Fiscal Note: Less than $500 to update policy database.
<table>
<thead>
<tr>
<th>Policy Number/Title</th>
<th>Text</th>
<th>Recommended Action and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-10.972, Blocked Fire Exits</td>
<td>AMA policy is that fire exits remain unlocked at all meetings of Federation members. The AMA will issue a statement that physicians should make certain that the observable fire exits are unlocked at any public gathering which they attend.</td>
<td>Sunset. Over the past 20 years fire safety regulations have been comprehensively promulgated by the International Code Council International Fire Code and the National Fire Protection Association Fire Protection Code, elements of which are included in all state and municipal fire codes. Codes distinguish between a fire exit and a fire door. A fire exit is an external door, which also functions as a security door. If locked to prevent unauthorized access from the outside, it must be fitted with a panic or push bar. Fire exit doors may also be fitted with a key lock override to allow outside access. A fire door is required to be kept closed at all times unless certified retainers are installed to hold it door open until a fire alarm is set off.</td>
</tr>
<tr>
<td>H-25.996, Retirement and Hiring Practices</td>
<td>It is urged that physicians, individually and through their constituent, component, and specialty medical societies, continue to stress the need to reappraise policies calling for compulsory retirement and age discrimination in hiring from the standpoint of health among older people, and that they participate actively and lend medical weight in the efforts of other groups to create a new climate of opportunity for the older worker.</td>
<td>Retain as editorially amended.</td>
</tr>
<tr>
<td>H-405.991, Volunteerism and Community Service</td>
<td>The AMA supports continued promotion of community service and volunteerism by its membership.</td>
<td>Reconcile with H-405.996, Voluntary Service by Physicians, “Our AMA does not believe it would be appropriate to establish a separate committee to serve as a clearinghouse for service opportunities and to promote voluntary service, but encourages state association awards for exceptional voluntary community service and wider recognition of physicians who perform voluntary services.”</td>
</tr>
<tr>
<td>H-445.999, Chambers of Commerce</td>
<td>The AMA reaffirms its previously adopted recommendation to all state medical societies that they become active in the U.S. and state chambers of commerce and requests that a similar recommendation be made to all county medical societies so that they too might be encouraged to become active in local, state and U.S. chambers of commerce programs.</td>
<td>Sunset. Action requested has been accomplished.</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

To fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients. As a profession, medicine should provide meaningful opportunity for physicians to hone their ability to be self-reflective.
The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the AMA Code of Medical Ethics [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

Yet despite the centrality of competence to professionalism, the Code has not hitherto examined what the commitment to competence means as an ethical responsibility for individual physicians in day-to-day practice. This report by the Council on Ethical and Judicial Affairs explores this topic to develop ethics guidance for physicians.

DEFINING COMPETENCE

A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional assessments of physicians’ technical knowledge and skills. However, this report is not concerned with matters of technical proficiency assessed by medical schools and residency programs, specialty boards (for purposes of certification), or hospital and other health care organizations (e.g., for privileging and credentialing). Such matters lie outside the Council’s purview.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. For purposes of this analysis, competence is understood as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served” and as “developmental, impermanent, and context dependent” [10].

Moreover, the Council is keenly aware that technical proficiency evolves over time—what is expected of physicians just entering practice is not exactly the same as what is expected of mid-
career physicians or physicians who are changing or re-entering practice or transitioning out of active practice to other roles. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues.

The concept that informs this report differs as well from the narrower definition of competence as the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice that enable physicians to assure patients, the public, and the profession that they provide safe, high quality care moment to moment over the course of a professional lifetime.

FROM SELF-ASSESSMENT TO “INFORMED” SELF-ASSESSMENT

Health care institutions and the medical profession as a whole take responsibility to regulate physicians through credentialing and privileging, routinely testing knowledge (maintenance of certification, requirements for continuing education, etc.) and, when needed, taking disciplinary action against physicians who fail to meet expectations for competent, professional practice. However, the better part of the responsibility to maintain competence rests with physicians’ “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs to maintain a level of competence commensurate with [their] clinical roles” [11].

Self-assessment has thus become “integral to many appraisal systems and has been espoused as an important aspect of personal professional behavior by several regulatory bodies and those developing learning outcomes for students” [12]. Undergraduate and graduate medical education programs regularly use self-assessment along with third-party evaluations to ensure that trainees are acquiring the knowledge and skills necessary for competent practice [5,10,13-16].

Yet how accurately physicians assess their own performance is open to question. Research to date suggests that there is poor correlation between how physicians rate themselves and how others rate them [5,12,13]. Various studies among health professionals have concluded that clinicians and trainees tend to assess their peers’ performance more accurately than they do their own; several have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves [5,12,17].

The available findings suggest that self-assessment involves an interplay of factors that can be complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess practical skills or theoretical knowledge) can all affect self-assessment [12,18]. The published literature also indicates that interventions intended to enhance self-assessment may seek different goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

Self-assessment tools alone are not sufficient measures of physicians’ ability to provide safe, high quality care. Feedback from third parties is essential—or as one researcher has observed, “The road to self-knowledge may run through other people” [19]. However, physicians are often wary of assessment. They have indicated that while they want feedback, they are not sure how to use information that is not congruent with their self-appraisals [20]. Physicians can be hesitant to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of concern that soliciting feedback could adversely affect their relationships with those whom they approach [20].
They may also question the accuracy and credibility of the assessment process and the data it generates [21].

To be effective, feedback must be valued both by those being assessed and by those offering assessment [14]. When there is tension between the stated goals of assessment and the implicit culture of the health care organization or institution, assessment programs can too readily devolve into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20]. Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews (“360° reviews”), for example, are generally better suited to providing feedback on communication and interpersonal skills than on technical knowledge or skills—and easy for evaluators to understand and use [14]. High quality feedback will come from multiple sources; be specific and focus on key elements of the ability being assessed; address behaviors rather than personality or personal characteristics; and “provide both positive comments to reinforce good behavior and constructive comments with action items to address deficiencies” [22]. Beyond such formal mechanisms, physicians should welcome and seek out informal input from colleagues. They should be willing to offer timely comments to colleagues as well.

One study among physicians and physicians in training found that participants used a dynamic, multidimensional process to assess their own abilities. Under this process of what researchers identified as “informed self-assessment,” participants interpreted and responded to multiple types of information, such as cognitive and affective data, from both formal and informal sources [23]. Participants described “critically reflecting ‘in action,’ that is, during an activity or throughout the day:”

I think we do a lot of it without thinking of it as reflection. We do it every day when we look at a patient’s chart. You look back and see the last visit, “What did I do, or should I have done something different?” I mean that’s reflection, but yet I wouldn’t have thought of that as self-assessment or self-reflection, but we do it dozens of times a day [23].

EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians’ thought processes are as important as their knowledge base or technical skills. Thus, understanding competence requires understanding something of the nature of expertise and processes of expert reasoning, themselves topics of ongoing exploration [24,25,26,27]. Prevailing theory distinguishes “fast” from “slow” thinking; that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate, analytical processes that require more conscious effort [26]. Some scholars take expertise to involve “fast” processes, and specifically decision making that involves automatic, nonanalytic resources acquired through experience [24]. Others argue that expertise consists in using “slow,” effortful, analytic processes to address problems [24]. A more integrative view argues that expertise resides in being able to transition between intuitive and analytical processes as circumstances require. On this account, experts use automatic resources to free up cognitive capacity so that they maintain awareness of the environment (“situational awareness”) and can determine when to shift to effortful processes [24].

Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s] automatic resources and to transition appropriately to a greater reliance on effortful processes when needed” [24], a practice described as “slowing down.” Knowing when to slow down and be reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To respond to the unexpected events that often arise in a clinical situation, the physician must “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to
transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should” serves as a critical marker for intraoperative surgical judgment [24].

INFLUENCES ON CLINICAL REASONING

Clinical reasoning is a complex endeavor. Physicians’ capabilities develop through education, training, and experiences that provide tools with which to shape their clinical reasoning. Every physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or differ from the analytical and investigative processes of their colleagues in innumerable ways. When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics and habits of perception, and succumbing to overconfidence.

Heuristics

Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While heuristics can be useful tools to help physicians identify and categorize relevant information, these time-saving devices can also derail decision making. For example, a physician may mistakenly assume that “something that seems similar to other things in a certain category is itself a member of that category” (the representative heuristic) [28], and fail to diagnose a serious health problem. Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that the physician proceeds to discount as stress or intoxication once the physician learns that the patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may miscalculate the likelihood of a disease or injury occurring by placing too much weight “on examples of things that come to mind easily, . . . because they are easily remembered or recently encountered” (the availability heuristic) [28]. For example, amidst heavy media coverage of an outbreak of highly infectious disease thousands of miles away in a remote part of the world, a physician seeing a patient with symptoms of what is actually a more commonplace illness may misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

Clinical reasoning can be derailed by other common cognitive missteps as well. These can include misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to remember information transferred at the beginning (or end) of an exchange but not information transferred in the middle (primary or recency bias) [28,29,30].

Habits of Perception

Like every other person, physicians can also find themselves prone to explicit (conscious) or implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health behavior, among other features, to shape how they perceive the patient and how they engage with, evaluate and treat the individual. Basing one’s interactions with a patient on pre-existing expectations or stereotypes demeans the patient, undermines the patient’s relationship with the physician and the health care system, and can result in significant health disparities across entire communities [31]. This is of particular concern for patients who are members of minority and historically disadvantaged populations [31]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting information that does not fit into predetermined beliefs (confirmatory bias) [28]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.
No matter how well a patient may seem to fit a stereotype, it is imperative that the physician look beyond categories and assumptions to investigate openly the health issues experienced by the patient. Although all human beings exhibit both conscious and unconscious habits of perception, physicians must remain vigilant in not allowing preconceived or unexamined assumptions to influence their medical practice.

Overconfidence

Finally, another obstacle to strong clinical reasoning that physicians may encounter is overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying the gaps in their knowledge [28,30]. Physicians may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [30]. Overconfidence in one’s abilities can lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one’s limits [28,30].

To avoid falling into such traps, physicians must recognize that many factors can and will influence their clinical decisions [28]. They need to be aware of the information they do and do not have and they need to acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [28]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming aware of areas in which their skills are not at their strongest and seeking additional education or consulting with colleagues, physicians can enhance their practice and best serve their patients.

FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [32]. Self-assessment, it is suggested, is a mechanism for identifying both one’s weaknesses and one’s strengths. One should be aware of one’s weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that “should be accepted as forever outside one’s scope of competent practice” [32]. Knowing one’s strengths, meanwhile, allows a physician both to “act with appropriate confidence” and to “set appropriately challenging learning goals” that push the boundaries of the physician’s knowledge [32].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in the moment is critical to physicians’ ethical responsibility to practice safely, at the top of their expertise but not beyond it.
Expert practitioners rely on pattern recognition and other automatic resources to be able to think and act intuitively. As noted above, an important component of expert judgment is transitioning effectively from automatic modes of thinking to more effortful modes as the situation requires.

Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to “slow down” during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [25].

Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [34,35], by disrupting memory processes, particularly the “prospective memory”—i.e., “a memory performance in which a person must recall an intention or plan in the future without an agent telling them to do so”—important for resuming interrupted tasks [35,36]. Systems-level interventions have been shown to help reduce the number or type of interruptions and distractions and mitigate their impact on medical errors [37].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being at the boundaries of one’s knowledge and responding accordingly [33]. Slowing down, looking things up, consulting a colleague, or deferring from taking on a case can all be appropriate responses when physicians’ self-awareness tells them they are at the limits of their abilities. The capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of competence broadly understood:

Safe practice in a health professional’s day-to-day performance requires an awareness of when one lacks the specific knowledge or skill to make a good decision regarding a particular patient. . . . This decision making in context is importantly different from being able to accurately rate one’s own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of self-efficacy and ongoing ‘reflection-in-practice,’ addressing emergent problems and continuously monitoring one’s ability to effectively solve the current problem [32].

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills [32]. Self-aware physicians are also alert to how external stressors—the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their professional careers. This ideal holds not just over the course of a sustained clinical practice, but equally when physicians re-enter practice after a hiatus, transition from active patient care to roles as educators or administrators, or take on other functions in health care. Self-assessment and self-awareness are central to achieving that goal.

A variety of strategies are available to physicians to support effective self-assessment and help physicians cultivate the kind of self-awareness that enables them to “know when to slow down” in
day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in
the form of written descriptions, audio or video recording, or photos of encounters with patients
that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to
improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike
standardized examinations, they are drawn from one’s actual work and require self-reflection [15].

As noted above, to be effective, self-assessment must be joined with input from others. Well-
designed multi-source feedback can be useful in this regard, particularly for providing information
about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple
response that elicits feedback about how well one maintains trust and professional relationships
with patients, one’s communication and teamwork skills, and accessibility offers a valid, reliable
tool that can have practical value in helping to correct poor behavior and, just as important,
consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful
feedback will not have the rigor of a validated tool but can accomplish similar ends.

Reflective practice, that is, the habit of using critical reflection to learn from experience, is
essential to developing and maintaining competence across a physician’s practice lifetime [38]. It
enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional
culture,” and to bridge new and existing knowledge. Studies suggest that reflective thinking can be
assessed, and that it can be developed, but also that the habit can be lost over time with increasing
years in practice [38].

“Mindful practice,” that is, being fully present in everyday experience and aware of one’s own
mental processes (including those that cloud decision making) [39], sustains the attitudes and skills
that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on
behavior over consciousness, erects barriers to mindful practice, while an individual’s unexamined
negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can
be self-taught, but for most it is most effectively learned in relationship with a mentor or guide.
Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness.
Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of
encounters with patients, or seeking insight from critical incident reports [39].

“Exemplary physicians,” one scholar notes, “seem to have a capacity for self-critical reflection that
pervades all aspects of practice, including being present with the patient, solving problems,
eliciting and transmitting information, making evidence-based decisions, performing technical
skills, and defining their own values” [39].

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the
remainder of this report be filed:

The expectation that physicians will provide competent care is central to medicine. It
undergirds professional autonomy and the privilege of self-regulation granted by society. To
this end, medical schools, residency and fellowship programs, specialty boards, and other
health care organizations regularly assess physicians’ technical knowledge and skills.

However, as an ethical responsibility competence encompasses more than medical knowledge
and skill. It requires physicians to understand that as a practical matter in the care of actual
patients, competence is fluid and dependent on context. Each phase of a medical career, from
medical school through retirement, carries its own implications for what a physician should
know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

(a) Cultivate continuous self-awareness and self-observation;

(b) Recognize that different points of transition in professional life can make different demands on competence;

(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations;

(d) Seek feedback from peers and others; and

(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500.
REFERENCES

Subject: Mergers of Secular and Religiously Affiliated Health Care Institutions

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Peter H. Rheinstein, MD, JD, MS, Chair)

Mergers between secular and religiously affiliated hospitals are changing the landscape of health care across the United States. This report by the Council on Ethical and Judicial Affairs (CEJA) offers ethics guidance to address the challenges such mergers can pose for patients, physicians, health care institutions and the communities they serve.

RELIGIOUSLY AFFILIATED HEALTH CARE INSTITUTIONS

The concept of the hospital as a facility providing inpatient care for the sick originated with the Catholic Church, with the original and enduring dual mission of healing the body and promoting spiritual well-being [1]. The mission of today’s Catholic Health Association remains focused on the needs of those who are “poor, underserved, and most vulnerable” [2]. Although hospitals established by Protestant denominations and Jewish-identified facilities remain important segments of U.S. health care, Catholic facilities predominate among religiously affiliated institutions—U.S. Catholic Health Care is the largest nonprofit care provider in the country [2].

Since the 1990s, mergers between secular and religiously affiliated hospitals and health care institutions have been reshaping the landscape of health care in the United States, for both patients and physicians. Driven by economic considerations and changes in health policy, notably in recent years emphasis on accountable care organizations and bundled payments [1,3], mergers have enabled facilities in some cases simply to survive and in others to thrive within their communities. Consolidation has enabled hospitals to control a greater share of their local markets and to negotiate effectively with insurers [4].

Religiously affiliated hospitals and facilities benefit from the tax-exempt status of the religious institutions they represent and from other tax subsidies that derive from their mission to serve the poor and provide charitable care [5]. Although the majority of religiously affiliated hospitals remain nonprofit, the number of for-profit hospitals affiliated with religious institutions increased by 22 percent between 2001 and 2016 [6]. Religiously affiliated health care facilities—which encompass clinics, hospitals, and long-term care facilities—are also important employers. According to the Catholic Health Association, as of 2017 member facilities employed more than 500,000 full-time and 200,000 part time staff [2].
In some communities, religiously affiliated health care institutions may be the only providers [6]—as of 2015, 132 of the nation’s approximately 1,300 critical access hospitals were members of U.S. Catholic Health Care [2]. In some areas, more than 40 percent of short-term, acute care beds are in Catholic facilities [6]. Nationwide, one in every six patients now receives care in a Catholic hospital [2].

THE DILEMMA OF MERGERS

The consolidation of a religiously affiliated institution with a secular health care facility raises challenges for all stakeholders—the facilities, their communities, their patients, and the physicians and other professionals who provide care. All religiously affiliated institutions seek to remain faithful to their defining mission and values, which can place them in tension with their secular counterparts. Catholic facilities, however, are embroiled in an increasingly public debate about the implications and effects of entering into arrangements with secular institutions as they seek to retain their identity and mission and still survive in the health care market place. Thus they offer a window through which to understand the ethical dimension of health care mergers.

As the Ethical and Religious Directives that govern care in Catholic health care facilities observe:

New partnerships can be opportunities to realign the local delivery system in order to provide a continuum of health care to the community; they can witness to a responsible stewardship of limited health care resources; and they can be opportunities to provide to poor and vulnerable persons a more equitable access to basic care.

On the other hand, new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles (§VI)[7].

From this perspective, in the contemporary health care market place Catholic hospitals “are caught in an impossible bind” [1]. Like other hospitals, financial pressures drive them to consolidate with other institutions to become more economically efficient. Yet “competing in the aggressive world of the medical business industry” can put Catholic hospitals’ historical commitment to the poor at risk [1]. At the same time, gaining financial security may risk “imperceptibly compromising their traditional Catholic witness” when compromises are made with respect to Directives [1].

From the perspective of those they serve, a merger or consolidation may help guarantee the continued presence of health care in a community, but may also limit the range of services available to patients when the consolidated entity adheres to the Directives. Certain treatment choices for care at the end of life, reproductive health care services, and, by some reports, certain services for transgender individuals may all be affected [4,8,9]. Limitations on women’s health services have been a focus of concern for obstetricians and gynecologists associated with or employed by religiously affiliated hospitals [10], with reports of conflict over both elective and clinically indicated surgical sterilization [11,12], and management of miscarriage [13]. Restricted access to services can have a disproportionate impact on poor women, and women in rural areas where religiously affiliated institutions are the only providers of care [14].

From the perspective of physicians and other health care professionals affiliated with or employed by the entity that results from a merger can challenge professional commitments. A merger that results in loss of access to services for the community and requires physicians to follow the religious guidelines embodied in the Directives may result in “conflict with prevailing medical...
standards of care and ethical principles of health care professional” [15]. Physicians and other
health care professionals who are not members of the faith tradition may find themselves
contractually prohibited from providing care that is otherwise legal and, in their professional
judgment, clinically appropriate and ethically permissible under the norms of medical
professionalism.

THE RESPONSIBILITIES OF LEADERSHIP

As challenging as mergers between secular and religiously affiliated health care facilities may be
for individual patients and physicians, addressing dilemmas of mission is pre-eminently a
responsibility of hospital leadership.

For Catholic facilities merging with secular facilities (or facilities associated with other religious
traditions), a touchstone is the principle of cooperation [16,17]. The principle, it is argued, is a
necessity for business relationships in a pluralistic world, providing a way to address the reality
that, for the faithful, “it is almost impossible to bring about good without brushing up against or
ev en becoming somewhat involved in the wrongdoing of others” [16]. The principle of cooperation
is understood “as a limiting principle, to avoid cooperating in evil” (original emphasis) [17].

The essential goal is to ensure that institutional arrangements allow the facility and its staff to
“remain as removed as possible” from violations of the Directives and “not [to] contribute anything
essential to make possible the wrongdoing’s occurring” [16]—e.g., essential employed staff or
equipment for the performance of what under the Directives is an immoral procedure [17]. Whether
services that would be otherwise prohibited by the Directives will or may be available through the
merged entity is importantly a function of how caregiving is organized in the resulting composite
system. The approval of the diocesan bishop is required for mergers involving facilities subject to
his governing authority, and the diocesan bishop has final authority for assessing whether a
proposed merger constitutes morally licit cooperation (§VI) [7].

Analogous discussions of the ethics of trusteeship, such as that offered by The Hastings Center,
offer secular insight for thinking about the responsibilities of leaders in health care institutions.
Trustees of not-for-profit health care organizations “regularly make decisions that affect the lives
and well-being of a large number of people who are relatively powerless, relatively vulnerable, and
in need of services or assistance” [18]. In light of the mission of such organizations, service on a
board of trustees entails fiduciary duties to founders, benefactors, and donors and responsibility to
ensure that the organization realizes the public benefits for which it enjoys tax exempt status.

Trustees are held to principles of fidelity to mission; service to patients, ensuring that the care is
high quality and provided “in an effective and ethically appropriate manner”; service to the
community the hospital serves, deploying hospital resources “in ways that enhance the health and
quality of life” of the community; and institutional stewardship. They have a further responsibility
to ensure that when there is conflict over fundamental values and principles, “all points of view are
heard and taken seriously, that reasonable compromise is explored, and that consensus has time to
form” [18].

The Principles of Integrated Leadership for Hospitals and Health Care Systems, developed in
collaboration by the American Hospital Association (AHA) and the American Medical Association
(AMA), address responsibilities of hospital leadership in the context of rapidly evolving models of
integrated physician-hospital health care systems [19]. In addition to governance and management
structure and leadership development, guidance identifies “cultural adaptation” as a key element
for success, observing that:
Culture is the way an organization, institution or integrated health system does business, in a way that is predictable, known to all and consonant with the mission and values of the organization, institution or integrated health system. The creation of a common shared culture that includes an integrated set of values is important to serve as a guide to the entity and will serve as a touch point to help resolve the inevitable conflicts that will arise [19].

The AHA-AMA’s principles for Integrated Leadership for Hospitals and Health Systems urge integrated health systems to cultivate the characteristics of adaptive institutional culture, including a focus on the health of the entire population served; agreement to a common mission, vision, and values; mutual understanding and respect; and a sense of common ownership of the entity and its reputation [19].

INSIGHT FROM THE CODE OF MEDICAL ETHICS

As frontline clinicians, physicians (and other health care professionals) regularly confront the effects on patients’ lives and well-being of the institutional arrangements through which care is delivered. They have a responsibility to advocate for the resources patients need, as well as to be responsible stewards of the resources with which they are entrusted [20]. They must be able to make treatment recommendations in keeping with their best judgment as medical professionals [21]. And they are expected to uphold the ethical norms of medicine, including fidelity to patients and respect for patients as moral agents and decision makers [22].

Existing guidance on exercise of conscience by individual physicians suggests essential responsibilities of leadership in health care as well [22]. These include responsibility to engage in thoughtful consideration of the implications of institutional arrangements—whether arrangements sustain or risk undermining the personal and professional integrity of staff, cause moral distress, or compromise the ability to provide care. Leaders in health care institutions must be mindful that arrangements do not discriminate against or unduly burden individual patients or populations of patients, and of the burden arrangements may place on fellow professionals. And they must accept responsibility to take steps to ensure that services will be available to meet the patients and community the institution serves.

RECOMMENDATION

In light of this analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted, and the remainder of this report be filed:

The merger of secular health care institutions and those affiliated with a faith tradition can benefit patients and communities by sustaining the ability to provide a continuum of care locally in the face of financial and other pressures. Yet consolidation among health care institutions with diverging value commitments and missions may also result in limiting what services are available. Consolidation can be a source of tension for the physicians and other health care professionals who are employed by or affiliated with the consolidated health care entity.

Protecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it, is an essential, but challenging responsibility.

Physician-leaders within institutions that have or are contemplating a merger of secular and faith-based institutions should:
(a) Seek input from stakeholders to inform decisions to help ensure that after a consolidation the same breadth of services and care previously offered will continue to be available to the community.

(b) Be transparent about the values and mission that will guide the consolidated entity and proactively communicate to stakeholders, including prospective patients, physicians, staff, and civic leaders, how this will affect patient care and access to services.

(c) Negotiate contractual issues of governance, management, financing, and personnel that will respect the diversity of values within the community and at minimum that the same breadth of services and care remain available to the community.

(d) Recognize that physicians’ primary obligation is to their patients. Physician-leaders in consolidated health systems should provide avenues for meaningful appeal and advocacy to enable associated physicians to respond to the unique needs of individual patients.

(e) Establish mechanisms to monitor the effect of new institutional arrangements on patient care and well-being and the opportunity of participating clinicians to uphold professional norms, both to identify and address adverse consequences and to identify and disseminate positive outcomes.

Individual physicians associated with secular and faith-based institutions that have or propose to consolidate should:

(f) Work to hold leaders accountable to meeting conditions for professionalism within the institution.

(g) Advocate for solutions when there is ongoing disagreement about services or arrangements for care.

(New HOD/CEJA Policy)

Fiscal note: Less than $500
REFERENCES

1 Guinan P. Catholic hospitals, are mergers the way to go? Linacre Quarterly. 2014;81(2):107–110.
EXECUTIVE SUMMARY

Every year, a growing number of “medical tourists” cross borders to receive treatments and procedures, including elective cosmetic services that are less costly than in their home countries; “medically necessary” care that is available at lower cost or in a more timely fashion; for access to nonvalidated therapies or other services that for ethical or legal reasons are not available in the health care system where the patient resides. Sometimes patients travel at the recommendation of their own physicians or under the auspices of programs initiated by their health plans or employers; sometimes patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies.

Many aspects of medical tourism confound core ethical expectations regarding patients’ rights—to informed consent, continuity of care and access to their medical records (E-1.1.3)—and physicians’ responsibilities—to promote quality of care (E-1.1.6) and patient safety (E-8.6), to be prudent stewards of health care resources.

Physicians need to be aware of the implications of medical tourism for individual patients and the community. Collectively, the profession should support access to outcomes data about medical tourism and advocate for appropriate education for health care professionals as well as for appropriate oversight of medical tourism.

Individually, physicians should familiarize themselves with issues in medical tourism, including risks and possible benefits, to help support informed decision making when patients approach them about seeking care abroad and offer professional guidance as they would for any decision about care. They should advise patients who consult them in advance whether they are or are not willing to provide follow up care. Physicians who consult them in advance whether they are or are not willing to provide follow up care. Physicians should respond compassionately when patients who did not discuss traveling for care return seeking nonemergent follow-up services. Before declining to provide such care, physicians should consider carefully the nature and duration of their relationship with the patient, the likely impact on the patient’s well-being, the burden declining to provide care may impose on fellow professionals, and the likely impact on the health and resources of the community.
REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-18

Subject: Medical Tourism

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Peter H. Rheinstein, MD, JD, MS, Chair)

Policy H-460.896(a), “Stem Cell Tourism,” adopted at the 2016 Annual meeting, calls on the American Medical Association (AMA) to encourage study of “appropriate guidance for physicians to use when advising patients who seek to engage in stem cell tourism and how to guide them in risk assessment.”

In keeping with this policy, the Council on Ethical and Judicial Affairs (CEJA) was asked to develop ethics guidance for physicians in this area. Based on its review of relevant literature and its deliberations, the council concluded that guidance focusing on the broader phenomenon of medical tourism, of which stem cell tourism is only one example, would better serve the profession. The following report and recommendations thus provide broad guidance for physicians who interact with patients who seek or have received medical care outside the U.S.

EMERGENCE OF MEDICAL TOURISM

Every year, a growing number of “medical tourists” cross borders to receive treatments and procedures, often treatments that are unaffordable or unavailable to them at home [1]. In its broadest sense, “medical tourism” refers to any occasion on which patients travel outside their home geographic area to receive medical care elsewhere—for example, traveling to a center of excellence in another city or state. As most commonly used today, however, medical tourism refers to traveling to a foreign country to receive care. It encompasses international travel by wealthy patients from lower wage countries to medical centers in higher wage countries, notably the U.S. [2]. Increasingly, however, medical tourism is understood as travel in the opposite direction, from higher wage countries to less affluent countries where medical services are available at lower cost [2,3].

Estimations of how many patients travel abroad for care vary considerably, but appear to exceed one million [4,5]. In some instances, patients travel abroad for care at the recommendation of their own physicians or under the auspices of programs initiated by their health plans or employers [2,6,7]. In others, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies [2].

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.
MEDICAL SERVICES OFFERED

Medical tourists travel to address what they deem to be unmet personal medical needs [8], prompted by issues of cost, timely access to services, higher quality of care or perceived superior services, or to access services that are not available in their country of residence [9,10]. Patients may also go outside their usual health care system to achieve other goals, for example, to preserve anonymity [11]; immigrant patients may return to their country of origin to receive care in culturally familiar settings [9]. The care medical tourists seek may be elective procedures; medically necessary standard care; or care that is unapproved or legally or ethically prohibited in their home system [12].

Elective Procedures: “Cosmetic Tourism”

A significant and expanding portion of the medical tourism industry is comprised of individuals who seek cosmetic procedures that are available in their home country but are offered at often considerably lower cost elsewhere [11,13,14]. For example, 2011 data indicate that breast implants that would have cost approximately $6,000 in the U.S. were available for about 43 percent of that cost in Thailand (approximately $2,600) and less than 25 percent (approximately $1,248) in Cuba [11]. Because cosmetic procedures are generally not covered by insurance plans and patients must pay out of pocket, going abroad for a desired procedure can be an attractive option. However, as Australian researchers noted, “[t]he model of care by which these services are delivered limits preoperative assessment and follow up to a few days to a week” [14].

Medically Necessary Care: “Transplant Tourism”

Medical tourism also encompasses care that would be deemed “medically necessary,” such as cardiac care (coronary artery bypass grafts, heart valve replacements, angioplasty) and orthopedic surgery (hip and knee replacement, hip resurfacing, spinal fusion) [15]. Patients from publicly funded health care systems, such as Canada, Australia, or the U.K., cite long wait times at home as a primary reason for seeking care abroad [16], although they could receive needed care in their home system. Uninsured or underinsured patients in predominantly private health care systems, such as the U.S., travel to access needed care that would otherwise not be available to them [3].

Over the past decade “transplant tourism” has emerged as a particularly problematic form of medical tourism. As one critique noted, many of the patients who go abroad for an organ transplant are “middle-income Americans evading impoverishment by expensive, medically necessary operations” [17]. Self-insured employers may encourage transplant tourism in an effort to contain health care costs [18]. A study of transplant tourists who presented for follow-up care at one U.S. facility found that these patients “had a substantially lower mean dialysis time before transplantation” compared with patients who underwent transplant at the institution [19]. By one estimate, as of 2007 some 10 percent of transplants worldwide involved commercial sales of organs [20]. Organ trafficking and the exploitation of vulnerable donors in resource poor countries associated with transplant tourism led the international transplant community in 2008 to adopt principles intended to curb unethical transplant practices [20].

Unapproved/Investigational Therapies: “Stem Cell Tourism”

Other than therapies for blood disorders, there is no evidence that stem-cell-based interventions are efficacious. Yet the market in stem cell tourism continues to grow—by 2012 some 700 clinics worldwide offered stem cell therapy for spinal cord injury, cardiovascular disease, Parkinson’s and
a host of other conditions [21]. For the most part, these therapies are unapproved and unregulated [21,22].

A recent case highlights the dangers of stem cell therapy. Richard Gass, a retired attorney in the U.S., suffered a stroke that left one arm paralyzed and one leg with weakness. Although he was able to live independently, he encountered a story about the miraculous physical recovery of a professional athlete who had traveled to Russia for stem cell treatments following a serious injury. Convinced of the promise stem cell treatments could bring, and undeterred by his family’s concerns about the dangers of these therapies, he traveled to Mexico to receive stem-cell injections. Despite improvement in his mobility early on, within months Gass became paralyzed from the neck down. When he sought follow-up care from his U.S. health care team, they discovered that a large, rapidly growing tumor along his spine derived from foreign cells that could not be completely removed [23].

In 2013, the International Society for Stem Cell Research called on governments and professional organizations to discourage commercial provision of (autologous) stem cell interventions outside of clinical trials [24]. Governments are moving to strengthen or more stringently enforce legal regulations where they exist [25]. For example, the U.S. Food and Drug Administration has issued draft guides that increase clarity and suggest that the U.S. Food and Drug Administration is preparing to take increased regulatory action in response to stem cell interventions offered domestically [26].

Proscribed Therapies: “Reproductive Tourism” (“Fertility Exile”)

As another area of medical tourism, travel for reproductive services highlights in particular issues involving access to services that for legal or ethical reasons are not available in the health care system where the patient(s) reside, or that are denied to certain categories of patients [27,28]. Hence the suggestion that such travel might better be described as “fertility exile” [29]. As reproductive tourists, patients may cross borders to receive services that are not legally available in their home health care system (e.g., pre-implantation genetic diagnosis); services for which they do not qualify in their home system by reason of age or marital status (e.g., in vitro fertilization); or services denied by their home health care institutions or health systems based on social rather than clinical considerations (e.g., gestational surrogacy for male same-sex couples) [28]. By one estimate, some 5,000 cross-border IVF treatment cycles were performed in 25 countries in 2008 [30].

Like transplant tourism, reproductive tourism raises concerns about the exploitation of vulnerable populations and the commercialization of human biological materials, as well as about discrimination against classes of patients [28,30,31]. Travel for unapproved or prohibited services can also exploit medical tourists themselves, of course, when it trades on false hope [12].

IMPLICATIONS FOR PATIENTS, PHYSICIANS & HEALTH CARE SYSTEMS

Many medical tourists receive excellent care, but data suggest that issues of safety and quality can loom large. Substandard surgical care, poor infection control, inadequately screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home [32,33]. Patients who develop complications may need extensive follow-up care when they return home; for those who return with infections, the differential diagnosis is often broader than in their home country, further complicating follow-up care [33]. The often short recovery periods following treatment abroad also mean medical tourists
can face greater risk for deep vein thrombosis, pulmonary embolism, or other travel-related complications [5,14,33].

For example, in 2013, the Maryland Department of Health and Mental Hygiene dealt with the repercussions of medical tourists traveling outside the U.S. for cosmetic surgery. Public health officials, working with the CDC, identified 21 patients from six states who had traveled to the Dominican Republic for cosmetic procedures (liposuction, abdominoplasty, buttocks augmentation, breast augmentation, and breast reduction); 18 were confirmed to have rapidly growing *Mycobactenam abscessus* (RGM), likely because of poor sterilization procedures during their surgeries [13]. All patients were successfully treated, but their course of care was complicated. Among the nine patients for whom chart data were available, median onset of illness was 24 days after their surgical procedure. Of the five from whom RGM culture was positive, median time to laboratory confirmation was 79 days after their first presentation for care in the U.S. Eight were hospitalized in the U.S., five of them on more than two occasions. All nine underwent at least one therapeutic surgical procedure; seven required courses of antibiotics for three months or longer; seven were prescribed more than five different classes of antibiotics [13].

Cost of post-surgical care can also be a concern. Of the patients who responded to requests for information about cost, 13 used medical insurance, although four indicated that their insurer had declined to cover some costs. Ten patients indicated the illness had caused financial problems; two reported that indirect costs, such as inability to work, compounded their financial difficulty [13]. A review of data for patients hospitalized at London’s Royal Free Hospital between 2015 and 2017 following plastic surgery outside the U.K. found that among 21 patients, complications led to 18 in-patient admissions and 46 surgical procedures overall. The total cost of follow up care was £282,000 (U.S. $368,600); cost per patient averaged £13,500 (slightly less than U.S. $18,000) [34]. Chart review at Gold Coast University Hospital in Queensland, Australia, similarly found that between 2012 and 2013, the facility treated 12 patients for complications following cosmetic surgery abroad—including not only infection, but also pulmonary embolism—at a cost of AUS151,172.52 (approximately $115,800 U.S.) [14]. Similar additional costs are reported by U.S. facilities [5].

Medical tourism carries implications for patients’ home communities as well. For example, the financial costs of needed follow-up care fall on health care institutions and health insurers [10,12,32], which may be especially problematic in publicly funded health care systems [10,14]. Medical travel poses public health risks, providing means for moving bacteria and resistant genes globally [33]. The fact that patients may return to multiple home institutions from a single destination treatment center underscores the need for tracking medical travel and outcomes that currently is not being met [14,33].

Additionally, medical tourism carries implications for destination communities and health care systems. It can foster dual systems of care, one catering to medical tourists, and one for the local population, a situation that risks exacerbating health inequity [10,32,35]. Development of commercial health care institutions to serve medical tourists risks creating, in the words of one author, “islands of medical excellence in a sea of medical neglect” [31]. Transplant and reproductive tourism in particular pose significant risk that vulnerable local populations will be exploited as donors of biological materials that benefit foreign patients [20,31].

GUIDANCE FROM PROFESSIONAL ORGANIZATIONS

In 2008, the American Medical Association adopted H-450.937, “Medical Care outside the United States,” which advocates that entities that “facilitate or incentivize” medical care outside the U.S.
ensure that such care is voluntary, take care that financial incentives neither limit the alternatives
offered to patients nor restrict treatment or referral, and refer patients only to internationally
accredited institutions. Policy further urges that local follow-up care and financing be coordinated
prior to travel and that coverage include costs of necessary follow-up care in the U.S. Patients
should be informed about their rights and legal recourse and should have access to information
about the foreign facility and health care professionals, the potential risks of combining surgical
procedures with travel, and outcomes data for the procedure(s) they will undergo. Transfer of
medical records to and from facilities outside the U.S. should adhere to HIPAA requirements.
Policy also supports reporting and tracking safety and quality data for procedures performed
outside the U.S. Substantially similar guidelines were published by the American Society for
Metabolic and Bariatric Surgery.

Also in 2008, the Transplantation Society and the International Society of Nephrology jointly
developed the Declaration of Istanbul on Organ Trafficking and Transplant Tourism to promote
and uphold ethical practice in organ transplantation internationally [20]. The following year, the
American College of Surgeons issued a position statement on medical and surgical tourism that
supports patients’ right to choose where and from whom they receive care and encourages College
Fellows to support informed decision making. The statement advises patients to consider not only
medical, but also “social, cultural and legal implications of seeking treatment abroad,” as well as to
seek care at an accredited institution and to obtain a complete copy of their medical records before
returning to the U.S [36]. In 2013, the International Society for Stem Cell Research similarly issued
a critique of commercial stem cell therapy and called for adherence to ethical standards regarding
interventions whose clinical value has not yet been demonstrated [24].

Several professional medical organizations have published cautionary information for patients
about medical tourism, including the American Academy of Facial and Plastic Surgery [37], the
American Society of Hematology [38], the American Society of Plastic Surgery [39], and the
American Society for Metabolic and Bariatric Surgery [40].

ETHICAL CHALLENGES OF MEDICAL TOURISM

Medical tourism can leave home country physicians in problematic positions: Faced with the
reality that medical tourists often need follow-up when they return, even if only to monitor the
course of an uneventful recovery; confronted with the fact that returning medical tourists often
don’t have records of the procedures they underwent and the medications they received, or contact
information for the foreign health care professionals who provided services; asked to make right
what went wrong when patients experience complications as a result of medical travel, often
having not been informed about, let alone part of the patient’s decision to seek health care abroad
[41].

Many aspects of medical tourism confound core ethical expectations regarding patients’ rights—to
informed consent, continuity of care and access to their medical records (E-1.1.3)—and physicians’
responsibilities—to promote quality of care (E-1.1.6) and patient safety (E-8.6), to be prudent
stewards of health care resources (E-11.1.2). Patients’ decisions to seek medical care abroad may
also threaten trust [41] and the integrity of patient-physician relationships. These challenges are
fundamentally systemic, yet patients often expect individual physicians to find ways to address
them.
Informed Decision Making

Ensuring that patients make informed decisions about seeking care abroad is not possible unless patients let physicians know they are considering doing so. Expecting physicians to routinely screen patients for possible interest in becoming a medical tourist is not realistic, but when a patient expresses concern about access to certain services, or a desire to receive care that is generally not available in the community, physicians should recognize the possibility that the patient is contemplating going outside the local system of care and explore the patient’s concerns and wishes more fully.

When patients’ responses indicate interest in medical tourism, it is reasonable to expect physicians will help ensure that patients have the information they need to make well-considered decisions. Physicians might do so by addressing the pros and cons of medical tourism themselves when they have relevant knowledge, by referring the patient to a specialist who has relevant expertise, or by directing the patient to other resources on medical tourism for the procedure, such as specialty society or government information pages.

Continuity of Care

Arguably, the extent of individual physicians’ ethical responsibility to provide after care for patients who have undergone a medical procedure abroad as a medical tourist will vary with the circumstances. Physicians have a responsibility to provide urgently needed care, or refer the patient appropriately (Principle VI), and to provide or refer for needed follow-up care when a current patient has received emergency medical care abroad. They are likewise expected to honor contractual obligations to provide care (E-1.1.2).

In other circumstances, however, physicians’ ethical responsibility may be less stringent, particularly when patients have traveled for elective procedures. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing (E-1.1.7) [8]. Beyond carefully considering the likely effect on the individual patient’s welfare, physicians should take into account whether they have the resources to provide the needed care safely and the likely effects providing care or declining to do so will have on their ability to meet the needs of other patients in their practice (E-1.1.2). Physicians have a further responsibility to reflect on the burden declining to provide follow-up care may impose on fellow professionals (cp. E-1.1.7), and on the likely impact on the health and resources of the community (E-11.1.2).

Preserving Trust

Patients may be hesitant to discuss medical tourism, fearing their physician’s reaction [41]. Physicians have a responsibility to offer their best professional guidance about a patient’s decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to obtain specific care abroad not to be in the patient’s best interests and helping the patient understand why they believe that to be the case. To protect the trust on which an effective therapeutic relationship is grounded, physicians should acknowledge the patient’s goal for seeking care. As patient advocates, they should help ensure that the patient has exhausted options for getting the desired care within their home health care system [42]. This includes encouraging patients who propose to travel for an unapproved therapy to enroll in appropriate clinical trials.

When patients inform them before they travel, physicians should advise the patient about the level of care they will or will not be able or willing to provide when the patient returns (cp. E-1.1.7).
When a patient who did not inform the physician in advance returns seeking follow-up care for treatment received abroad, physicians must decide whether to provide that care. The obligation of compassion does not automatically translate into a duty to treat except in an emergency. However, before declining to provide needed after care to a medical tourist, physicians should carefully consider the effect that decision is likely to have on the patient’s welfare, other health care professionals, and the community.

Oversight

The European Union has established formal guidelines for cross-border care among member countries [43], and entities such as the Joint Commission International and Accreditation Canada accredit international health care facilities [32], but at present, medical tourism is otherwise regulated only to the extent that medical practice in individual countries is regulated. Medical tourism companies as such are not regulated at all. Nor do medical tourism agents receive specific training or certification [32]. The absence of systematic collection and reporting of data about outcomes leaves patients, physicians, and health care systems in the dark, impeding informed decision making about medical tourism and obscuring potential risks to public health. Physicians have firsthand knowledge of the experience of individual patients who have become medical tourists and are well positioned to advocate for standards to improve quality of care and protect the interests of patients who seek care abroad.

RECOMMENDATION

In view of these considerations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report filed:

Medical tourists travel to address what they deem to be unmet personal medical needs, prompted by issues of cost, timely access to services, higher quality of care or perceived superior services, or to access services that are not available in their country of residence. In many instances, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies. The care medical tourists seek may be elective procedures, medically necessary standard care, or care that is unapproved or legally or ethically prohibited in their home system.

Many medical tourists receive excellent care, but issues of safety and quality can loom large. Substandard surgical care, poor infection control, inadequately screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home. Medical tourists also face heightened travel-related risks. Patients who develop complications may need extensive follow-up care when they return home. They may pose public health risks to their home communities as well.

Medical tourism can leave home country physicians in problematic positions: Faced with the reality that medical tourists often need follow-up when they return, even if only to monitor the course of an uneventful recovery; confronted with the fact that returning medical tourists often do not have records of the procedures they underwent and the medications they received, or contact information for the foreign health care professionals who provided services, asked to make right what went wrong when patients experience complications as a result of medical travel, often having not been informed about, let alone part of the patient’s decision to seek health care abroad.
Physicians need to be aware of the implications of medical tourism for individual patients and the community.

Collectively, through their specialty societies and other professional organizations, physicians should:

(a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.

(b) Advocate for education for health care professionals about medical tourism.

(c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.

(d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.

Individually, physicians should:

(e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individual’s concerns and wishes about care.

(f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.

(g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.

(h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.

(i) Offer their best professional guidance about a patient’s decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to obtain specific care abroad not to be in the patient’s best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.

(j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physician’s prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider

(i) the nature and duration of the patient-physician relationship;

(ii) the likely impact on the individual patient’s well-being;

(iii) the burden declining to provide follow-up care may impose on fellow professionals;

(iv) the likely impact on the health and resources of the community.
Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services.

(NEW HOD/CEJA POLICY)

Fiscal Note: Less than $500.
REFERENCES

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 4-A-18

Subject: Expanded Access to Investigational Therapies

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Peter H. Rheinstein, MD, JD, MS, Chair)

Policy D-460.967(2), “Study of the Current Uses and Ethical Implications of Expanded Access Programs,” instructs our American Medical Association (AMA) to “study the ethics of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access to investigational therapies, including access for infants and children.” This report by the Council on Ethical and Judicial Affairs (CEJA) examines ethical issues in relation to expanded access and offers guidance for physicians.

ACCESS TO INVESTIGATIONAL THERAPY

For some patients who face serious life-threatening or life-limiting conditions there are few or no approved therapies. For others, existing therapies are unlikely or have failed to be effective. In such situations, patients and their physicians may turn to as yet unapproved treatments as a last hope.

From a societal perspective, participating in a clinical trial is the most desirable way for patients to obtain access to therapies still in development [1,2]. But from the perspective of individual patients, enrolling in a randomized trial cannot guarantee access to the treatment they seek; some will not meet inclusion criteria to be accepted as trial participants even if they are willing to take the chance of being randomized to a control arm rather than the investigational therapy; still others may be unable to participate for other reasons. The expanded access program of the US Food and Drug Administration (FDA) allows patients in such circumstances to seek access to treatment with an investigational therapy outside a clinical trial.

Expanded Access (“Compassionate Use”)

“Expanded access” refers “the use of an investigational drug when the primary purpose is to diagnose, monitor, or treat a patient rather than to obtain the kind of information about the drug that is generally derived from clinical trials [3].

Following the thalidomide scandal of the late 1950s and early 1960s, in 1962 the US Congress mandated that the FDA validate the safety and effectiveness of new drugs based on substantial evidence collected from controlled clinical trials, which significantly lengthened the timelines for development of new drugs [4]. The FDA began allowing patients and physicians to petition for access to unapproved drugs [4], and in 1987 recognized “treatment IND [investigational new

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council

© 2018 American Medical Association. All rights reserved.
drug]” protocols in response to the HIV/AIDS crisis as dying AIDS patients sought access to the then-unapproved drug AZT [5].

With the push from advocacy groups such as ACT UP, the FDA agreed to allow pharmaceutical companies to offer access to other promising AIDS drugs through an “expanded access” (or “compassionate use”) protocol; Alzheimer and cancer patients and their advocates soon followed with similar demands for access to unproven therapies [5]. In 2009, the FDA substantially revised federal regulations (at 21 CFR 312), creating three categories for access to investigational therapies: use by individual patients, use by intermediate-sized patient populations (tens to hundreds), and widespread use after a clinical trial has been successfully completed but prior to FDA approval of the therapy [4,6].

Before a patient can legally receive an investigational therapy outside of a clinical trial, the FDA must approve the expanded access application submitted by the physician who will oversee treatment (21 CFR312.305). To be granted, a request must demonstrate that the patient(s) for whom access is requested has a “serious or immediately life-threatening” condition for which there is no satisfactory alternative therapy; that the potential benefit to the patient justifies the risk of the investigational therapy; and that the potential risks of the investigational therapy “are not unreasonable in the context of the disease or condition to be treated” (21 CFR 312.305). To protect the scientific integrity of clinical trials, it must also be shown that providing the investigational therapy “will not interfere with the initiation, conduct, or completion of clinical investigations that could support marketing approval of the expanded access use or otherwise compromise the potential development of the expanded access use” (21 CFR 312.305).

The regulations further set evidentiary thresholds for risk that are more stringent the greater number of patients involved and the less serious the condition. For single patient use, a physician need only conclude that the investigational therapy poses no greater risk than the disease itself (21 CFR 312.310), while for intermediate-size patient populations, there must be evidence that the drug is safe “at the dose and duration” proposed for expanded access use and that there is “at least preliminary clinical evidence of effectiveness” (or plausible pharmacologic effect) to make use under expanded access “a reasonable therapeutic option” for the intended patient population (21 CFR 312.315). Thus, patients who receive investigational therapies outside clinical trials don’t have the same protections as do enrolled participants, such as monitoring by institutional review boards and data and safety monitoring boards, which can halt trials when significant concerns arise [7]. Because patients receiving investigational therapies under expanded access are not connected to a particular trial site, “the potential for rigorous safety monitoring is greatly reduced” [7].

Under the 2009 regulations, the treating physician must determine that the proposed use meets FDA criteria for expanded access and is also responsible for obtaining IRB approval for use of the investigational therapy for the patient, which can be particularly challenging for physicians outside academic medical centers [4]. Physicians who treat patients with investigational therapies under expanded access must comply with the responsibilities for investigators set out elsewhere in federal regulations governing clinical trials. In 2017, the FDA took steps to streamline the process of applying for expanded access, simplifying the single patient application form and modifying the requirement for IRB approval to allow review by a single member of the IRB rather than the fully convened board [8]. FDA has indicated that further simplification is being considered [8].

Sponsors are not required to provide investigational therapies for use under expanded access, and FDA has no authority to mandate that a drug be made available by an unwilling sponsor [7]. Sponsors decline to participate in expanded access for a variety of reasons, including limited supply of the investigational therapy, limited capacity to produce additional supplies, or the cost of
making the therapy available outside an ongoing clinical trial [1,4]. Sponsors who provide an
investigational therapy under expanded access face additional administrative burdens—among
other requirements, regulations mandate that they ensure that physicians are qualified to administer
the therapy and submit investigational new drug safety reports for the expanded access use,
including reporting adverse events (21 CFR 312.305).

One concern is that adverse events reported for expanded access use may in fact not be associated
with the investigational therapy and could jeopardize development of it [1,9]. Patients who receive
an investigational therapy outside clinical trials may have more advanced disease than trial
participants, have other concurrent medical conditions, or be receiving other concurrent treatment,
which can make it more difficult to determine the cause of an adverse event. Responding to this
concern, the FDA recently clarified expectations for reporting negative effects, permitting sponsors
to report only those events for which “there is evidence to suggest a causal relationship between the
drug and the adverse event” [8].

Impact of Expanded Access

Applications for expanded access use for both drugs and biologics have grown steadily—from just
under 1,100 in 2010 to more than 1,700 in 2016 (with a high total of 1,999 in 2014) [10]. Overall,
the Center for Drug Evaluation and Research received nearly 11,000 applications between 2005
and 2014, of which 99.7% were approved [1]. The majority of requests were in “therapeutic areas
where products were being developed to treat life-threatening illness with significant unmet
medical need,” such as hematologic and solid organ malignancies [1].

Less is known about whether requests for expanded access use are granted by sponsors or whether
investigational therapies provided through expanded access have received FDA approval. A review
of found 398 expanded access programs registered at ClinicalTrials.gov as of July 2016 [11]. Of
the 210 unique experimental drugs for which data were reviewed, 76 percent had ultimately
received approval. As the authors note, this suggests that “we cannot entirely eliminate safety and
efficacy questions in expanded access and compassionate use” [11].

The Future of Expanded Access

Provisions of the 21st Century Cures Act enacted in December 2016 address the challenges patients
and physicians face in obtaining information about investigational therapies that may be available
through expanded access. The act requires manufacturers and distributors of investigational drugs
intended to treat serious diseases to “make public and readily available” their policies for
evaluating and responding to requests for expanded access use (Pub L 114-255). The act further
requires that such policies include contact information for the manufacturer or distributor,
procedures for making requests and general criteria used to evaluate requests for individual
patients, and a link or other reference to clinical trial information about the investigational therapy.
The act does not, however, require a manufacturer or distributor to guarantee access to an
investigational therapy in development.

In addition to simplifying application forms for single patient use and procedures for IRB approval,
in July 2017 FDA launched a new online Expanded Access Navigator in conjunction with the
Reagan-Udall Foundation to assist patients and physicians in finding information about expanded
access [8].
ETHICAL CHALLENGES IN EXPANDED ACCESS

Although ongoing efforts to simplify expanded access programs will likely enable more patients to receive treatment with investigational therapies, ethical concerns remain. Key among them are issues of informed consent and decision making, fairness in access to investigational therapies, and possible negative effects for the conduct of clinical trials.

Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and to ask questions about recommended treatments so that they can make well-considered decisions about care (E-2.1.1). Treatment with an investigational therapy poses special challenges in this regard. Patients who face serious, life-threatening illnesses for which approved therapies have not been effective or for which there are no approved therapies may be particularly vulnerable to holding out false hope for investigational therapy [12]. Promoting truly informed decisions about whether to request expanded access is critical, but can be difficult, both because information about an investigational therapy is often incomplete or difficult to obtain, and because patients may be prone to misinterpreting what information is available.

In the early stages of development, relatively little may be known about an investigational therapy’s efficacy or possible adverse effects [4,13]. Information about therapies still in development is often proprietary and thus not readily available, making it difficult for patients and physicians to assess whether the risk of disease outweighs the risk of the investigational therapy for purposes of requesting expanded access [4]. Moreover, terminally ill patients do not always evaluate risks and benefits objectively—they tend to overestimate likely benefit and underestimate the burdens of as yet unproven therapies [12,14]. They may be under a “therapeutic misconception” and fail to appreciate that the therapy has not been demonstrated to be effective [15], or be “unrealistically optimistic” and expect that their personal outcomes will be more positive than the outcomes of others in similar situations [14,16].

FDA acknowledges that patients who are candidates for expanded access use “are a particularly vulnerable population” and “should be afforded a rigorous informed consent process that effectively communicates the risks and potential benefits of any investigational therapy to be used for treatment use [sic] in a way that does not raise false expectations about a positive outcome from treatment and makes clear what is unknown about the drug” [6]. Expanded access regulations mandate that the treating physician (“investigator” in the language of the regulations) ensure that the consent requirements of the Common Rule are met (21 CFR 305(c)(4)), including informing the patient that the therapy is investigational and that there is uncertainty as to its safety and effectiveness [3].

FDA also mandates that the sponsor of an investigational therapy provide the treating physician “with the information needed to minimize the risk and maximize the potential benefits of the investigational drug (the investigator’s brochure must be provided if one exists for the drug)” (21 CFR 312.305(c)(5)) as a requirement for expanded access use. It is essential that the treating physician have as much information as possible about an investigational therapy to provide appropriate patient care. An investigator’s brochure “provides insight to support the clinical management of the study subject” [17]—or, in the instant case, the patient receiving the investigational therapy under expanded access—by compiling both clinical and nonclinical information about the therapy.
Financial Barriers to Expanded Access

Issues of equity also arise with respect to expanded access programs. Sponsors may provide investigational therapies at no cost for expanded access use, but they are not required to do so. Current FDA regulations permit sponsors to recover direct costs of providing an investigational therapy for expanded access use (21 CFR 312.8(d)(1)), either directly from patients or by billing third-party payers. For the most part, insurance plans do not reimburse the costs of therapies not yet approved for marketing [14,18]. Although most sponsors shoulder the cost burden, when they do not patients may be unable to afford to pay out of pocket, even when they have been approved for expanded access use. It has been argued that expanded access “favors the rich or well-connected” [4].

Effects on Clinical Trials/Implications for Public Health

Expanded access programs may also adversely affect the successful completion of clinical trials and marketing approval of clinical trials. Permitting patients to obtain not yet approved therapies by means of expanded access may delay enrollment in trials of the therapy or jeopardize retention of participants, undermining efforts to demonstrate the safety and efficacy of the investigational therapy [9]. This in turn thwarts society’s interest in the development and approval of new therapies for populations of patients [2,9]. The extent to which expanded access programs in fact have this effect is not clear. Before FDA will approve a request for expanded access use, patients and physicians must demonstrate that the patient is not a candidate for a clinical trial, for example, because the individual fails to meet inclusion criteria or existing trials are geographically inaccessible to the individual.

RECOMMENDATION

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that Policy D-460.967(2), “Study of the Current Uses and Ethical Implications of Expanded Access Programs,” be rescinded, the following be adopted, and the remainder of the report be filed:

Physicians who care for patients with serious, life-threatening illness for whom standard therapies have failed, are unlikely to be effective, or do not exist should determine whether questions about access to investigational therapy through the U.S. Food and Drug Administration’s “expanded access” program are likely to arise in their clinical practice. If so, physicians should familiarize themselves with the program to be better able to engage in shared decision making with patients.

When a patient requests expanded access to an investigational therapy, physicians should:

(a) Assess the patient’s individual clinical situation to determine whether an investigational therapy would be appropriate, including:

(i) whether there is a satisfactory alternative therapy available to diagnose, monitor, or treat the patient’s disease or condition;

(ii) the nature of potential risks of the investigational therapy and whether those risks are not unreasonable in the context of the patient’s disease or condition;

(iii) whether the potential benefit to the patient justifies the risks of the investigational therapy;
(iv) whether the patient meets inclusion criteria for an existing clinical trial of the investigational therapy.

(b) As part of the informed consent process, advise the patient (or parent/guardian if the patient is a minor) that the investigational therapy has not yet been demonstrated to be effective in treating the patient’s condition and may pose as yet unknown risks. Physicians should explain the importance of clinical trials, encourage patients who meet inclusion criteria to participate in an existing trial rather than seek access to investigational therapy through the FDA expanded access program, and direct patients who wish to participate in research to appropriate resources.

(c) Decline to support an application for expanded access to an investigational therapy when:

(i) the physician judges the treatment with the investigational therapy not to be in the patient’s best interest, and explain why; or

(ii) the physician does not have appropriate resources and ability to safely supervise the patient’s care under expanded access.

In such cases, physicians should refer the patient to another physician with whom to discuss possible application for expanded access.

(d) Discuss the implications of expanded access for the patient and family and help them form realistic expectations about what it will mean to be treated with the investigational therapy outside a clinical trial. Physicians should alert patients:

(i) to the possibility of financial or other responsibilities associated with receiving an investigational therapy through expanded access;

(ii) to the lack of infrastructure to systematically monitor and evaluate the effects of the investigational therapy outside a clinical trial;

(iii) that they need information about how to contact the manufacturer for guidance if they seek emergency care from a health care professional who is not affiliated with a clinical trial of the investigational therapy;

(iv) that the physician has a responsibility to collect and share clinical information about the patient’s course of treatment with the investigational therapy, as well as to report any adverse events that may occur over the course of treatment;

(v) to the conditions under which the physician would recommend stopping treatment with the investigational therapy.

(NEW HOD/CEJA POLICY)

Fiscal Note: Less than $500
REFERENCES

8. Gottlieb S. Expanded access: FDA describes efforts to ease application process. FDA Voice. 2017;October 3.
Subject: Study Aid-in-Dying as End-of-Life Option  
(Resolution 15-A-16)  
The Need to Distinguish “Physician-Assisted Suicide” and “Aid in Dying”  
(Resolution 14-A-17)  

Presented by: Dennis S. Agliano, MD, Chair  

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(Peter H. Rheinstein, MD, JD, MS, Chair)  

At the 2016 Annual Meeting, the House of Delegates referred Resolution 15-A-16, “Study Aid-in-Dying as End-of-Life Option,” presented by the Oregon Delegation, which asked:  

That our American Medical Association and its Council on Judicial and Ethical Affairs, study the issue of medical aid-in-dying with consideration of (1) data collected from the states that currently authorize aid-in-dying, and (2) input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician “aid-in-dying.”  

At the following Annual Meeting in June 2017, the House similarly referred Resolution 14-A-17, The Need to Distinguish between ‘Physician-Assisted Suicide’ and ‘Aid in Dying’” (presented by M. Zuhdi Jasser, MD), which asked that our AMA:  

(1) as a matter of organizational policy, when referring to what it currently defines as ‘Physician Assisted Suicide’ avoid any replacement with the phrase ‘Aid in Dying’ when describing what has long been understood by the AMA to specifically be ‘Physician Assisted Suicide’; (2) develop definitions and a clear distinction between what is meant when the AMA uses the phrase ‘Physician Assisted Suicide’ and the phrase ‘Aid in Dying’; and (3) fully utilize these definitions and distinctions in organizational policy, discussions, and position statements regarding both ‘Physician Assisted Suicide’ and ‘Aid in Dying.’  

This report by the Council on Ethical and Judicial Affairs (CEJA) addresses the concerns expressed in Resolutions 15-A-16 and 14-A-17. In carrying out its review of issues in this area, CEJA reviewed the philosophical and empirical literature, sought input from the House of Delegates through an I-16 educational program on physician-assisted suicide, an informal “open house” at A-17, and its I-17 Open Forum. The council wishes to express its sincere appreciation for participants’ contributions during these sessions and for additional written communications received from multiple stakeholders, which have enhanced its deliberations.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.
The council observes that the ethical arguments advanced today supporting and opposing “physician-assisted suicide” or “aid in dying” are fundamentally unchanged from those examined in CEJA’s 1991 report on this topic [1]. The present report does not rehearse these arguments again as such. Rather, it considers the implications of the legalization of assisted suicide in the United States since the adoption of Opinion E-5.7, “Physician-Assisted Suicide,” in 1994.

“ASSISTED SUICIDE,” “AID IN DYING,” OR “DEATH WITH DIGNITY”? Not surprisingly, the terms stakeholders use to refer the practice of physicians prescribing lethal medication to be self-administered by patients in many ways reflect the different ethical perspectives that inform ongoing societal debate. Proponents of physician participation often use language that casts the practice in a positive light. “Death with dignity” foregrounds patients’ values and goals, while “aid in dying” invokes physicians’ commitment to succor and support. Such connotations are visible in the titles of relevant legislation in states that have legalized the practice: “Death with Dignity” (Oregon, Washington, District of Columbia), “Patient Choice and Control at the End of Life” (Vermont), “End of Life Options” (California, Colorado), and in Canada’s “Medical Aid in Dying.”

Correspondingly, those who oppose physician provision of lethal medications refer to the practice as “physician-assisted suicide,” with its negative connotations regarding patients’ psychological state and its suggestion that physicians are complicit in something that, in other contexts, they would seek to prevent. The language of dignity and aid, critics contend, are euphemisms [2]; their use obscures or sanitizes the activity. In their view such language characterizes physicians’ role in a way that risks construing an act that is ethically unacceptable as good medical practice [3].

The council recognizes that choosing one term of art over others can carry multiple, and not always intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation and debate is best served by using plainly descriptive language. In the council’s view, despite its negative connotations [4], the term “physician assisted suicide” describes the practice with the greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia [1]. The terms “aid in dying” or “death with dignity” could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance.

COMMON GROUND Beneath the seemingly incommensurate perspectives that feature prominently in public and professional debate about writing a prescription to provide patients with the means to end life if they so choose, CEJA perceives a deeply and broadly shared vision of what matters at the end of life. A vision that is characterized by hope for a death that preserves dignity, a sense of the sacredness of ministering to a patient at the end of life, recognition of the relief of suffering as the deepest aim of medicine, and fully voluntary participation on the part of both patient and physician in decisions about how to approach the end of life.

Differences lie in the forms these deep commitments take in concrete decisions and actions. CEJA believes that thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physician-assisted suicide that govern how these shared commitments are ultimately expressed. For one patient, dying “with dignity” may mean accepting the end of life however it comes as gracefully as one can; for another, it may mean being able to exercise some measure of control over the circumstances in which death occurs. For some physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to
abandon the patient preclude the possibility of supporting patients in hastening their death. For others, not to provide a prescription for lethal medication in response to a patient’s sincere request violates that same commitment and duty. Both groups of physicians base their view of ethical practice on the guidance of Principle I of the AMA Principles of Medical Ethics: “A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.”

So too, how physicians understand and act on the goals of relieving suffering, respecting autonomy, and maintaining dignity at the end of life is directed by identity-conferring beliefs and values that may not be commensurate. Where one physician understands providing the means to hasten death to be an abrogation of the physician’s fundamental role as healer that forecloses any possibility of offering care that respects dignity, another in equally good faith understands supporting a patient’s request for aid in hastening a foreseen death to be an expression of care and compassion.

IRREDUCIBLE DIFFERENCES IN MORAL PERSPECTIVES ON PHYSICIAN-ASSISTED SUICIDE

How to respond when coherent, consistent, and deeply held beliefs yield irreducibly different judgments about what is an ethically permissible course of action is profoundly challenging. With respect to physician-assisted suicide, some professional organizations—for example, the American Academy of Hospice and Palliative Medicine [5]—have adopted a position of “studied neutrality.” Positions of studied neutrality neither endorse nor oppose the contested practice, but instead are intended to respect that there are irreducible differences among the deeply held beliefs and values that inform public and professional perspectives [5,6], and to leave space open for ongoing discussion. Nonetheless, as a policy position, studied neutrality has been criticized as being open to unintended consequences, including stifling the very debate it purports to encourage or being read as little more than acquiescence with the contested practice [7].

CEJA approaches the condition of irreducible difference from a different direction. In its 2014 report on exercise of conscience, the Council noted that “health care professionals may hold very different core beliefs and thus reach very different decisions based on those core beliefs, yet equally act according to the dictates of conscience. For example, a physician who chooses to provide abortions on the basis of a deeply held belief in protecting women’s autonomy makes the same kind of moral claim to conscience as does a physician who refuses to provide abortion on the basis of respect for the sanctity of life of the fetus” [8].

Importantly, decisions taken in conscience are not simply idiosyncratic; they do not rest on intuition or emotion. Rather, such decisions are based on “substantive, coherent, and reasonably stable” values and principles [8]. Physicians must be able to articulate how those values and principles justify the action in question.

The ethical arguments offered for more than two decades by those who support and those who oppose physician participation in assisted suicide reflect the diverging “substantive, coherent, and reasonably stable” values and principles within the profession and the wider moral community. While supporters and opponents of physician-assisted suicide share a common commitment to “compassion and respect for human dignity and rights” (AMA Principles of Medical Ethics, I), they draw different moral conclusions from the underlying principle they share. As psychiatrist Harvey Chochinov observed with respect to the stakeholders interviewed by Canadian Supreme Court’s advisory panel on physician-assisted death, “neither those who are strongly supportive nor those who are opposed hold a monopoly on integrity and a genuine concern for the well-being of
people contemplating end of life. Equally true: neither side is immune from impulses shaped more by ideology than a deep and nuanced understanding of how to best honor and address the needs of people who are suffering” [9].

THE RISK OF UNINTENDED CONSEQUENCES

From the earliest days of the debate, a prominent argument raised against permitting physician-assisted suicide has been that doing so will have adverse consequences for individual patients, the medical profession, and society at large. Scholars have cited the prospect that boundaries will be eroded and practice will be extended beyond competent, terminally ill adult patients; to patients with psychiatric disorders, children; or that criteria will be broadened beyond physical suffering to encompass existential suffering; or that stigmatized or socioeconomically disadvantaged patients will be coerced or encouraged to end their lives. Concerns have also been expressed that permitting the practice will compromise the integrity of the profession, undermine trust, and harm the physicians and other health care professionals who participate; and that forces outside medicine will unduly influence decisions.

The question whether safeguards—which in the U.S. jurisdictions that permit assisted suicide, restrict the practice to terminally ill adult patients who have decision-making capacity and who voluntarily request assisted suicide, along with procedural and reporting requirements—can actually protect patients and sustain the integrity of medicine remains deeply contested. Some studies have “found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups” [10], others question whether the available data can in fact support any such conclusions, finding the evidence cited variously flawed [11], inadequate [12], or distorted [13].

Although cross-cultural comparisons are problematic [14], current evidence from Europe does tell a cautionary tale. Recent findings from studies in Belgium and the Netherlands, both countries that permit euthanasia as well as physician-assisted suicide, mitigate some fears but underscore others [15]. For example, research in the Netherlands has found that “requests characterized by psychological as opposed to physical suffering were more likely to be rejected, as were requests by individuals who lived alone,” mitigating fears that “solitary, depressed individuals with potentially reversible conditions might successfully end their lives.” At the same time, however, among patients who obtained euthanasia or assisted suicide, nearly 4 percent “reported only psychological suffering.” At the level of anecdote, a description of a case of euthanasia in Belgium elicited widespread concern about the emergence of a “slippery slope” [16].

Studies have also raised questions about how effective retrospective review of decisions to provide euthanasia/assisted suicide is in policing practice [17,18]. A qualitative analysis of cases that Dutch regional euthanasia committees determined had not met legal “due care criteria” found that such reviews focus on procedural considerations and do not “directly assess the actual eligibility” of the patients who obtained euthanasia [17]. A separate study of cases in which psychiatric patients obtained euthanasia found that physicians’ reports “stated that psychosis or depression did or did not affect capacity but provided little explanation regarding their judgments” and that review committees “generally accepted the judgment of the physician performing EAS [euthanasia or physician-assisted suicide]” [18]. It remains an open question whether reviews that are not able to assess physicians’ reasoning truly offer the protection they are intended to provide. To the extent that reporting and data collection in states that permit physician-assisted suicide have similar limitations, oversight of practice may not be adequate.
Medicine must learn from this experience. Where physician-assisted suicide is legalized, safeguards can and should be improved—e.g., “[t]o increase safeguards, states could consider introducing multidisciplinary panels to support patients through the entire process, including verifying consent and capacity, ensuring appropriate psychosocial counseling, and discussing all palliative and end-of-life options” [19]. Both the state and the medical profession have a responsibility to monitor ongoing practice in a meaningful way and to address promptly compromises in safeguards should any be discovered. It is equally important that strong practices be identified and encouraged across all jurisdictions that permit physicians to assist suicide. Health care organizations in California and Canada, for example, have shared richly descriptive reports of practices adopted in response to the recent legalization of “aid in dying” in those jurisdictions that seek to address concerns about quality of practice and data collection [20,21].

Medicine must also acknowledge, however, that evidence (no matter how robust) that there have not yet been adverse consequences cannot guarantee that such consequences would not occur in the future. As a recent commentary noted, “[p]art of the problem with the slippery slope is you never know when you are on it” [15].

SAFEGUARDING DECISIONS AT THE END OF LIFE

CEJA has found that just as there are shared commitments behind deep differences regarding physician-assisted suicide, there are also shared concerns about how to understand the available evidence. For example, in the council’s recent Open Forum, both proponents and opponents of physician-assisted suicide observed that in the U.S., debate occurs against the backdrop of a health care system in which patients have uneven access to care, including access to high quality end-of-life care. They also noted that patients and physicians too often still do not have the conversations they should about death and dying, and that too few patients are aware of the range of options for end-of-life care, raising concern that many patients may be led to request assisted suicide because they don’t understand the degree of relief of suffering state-of-the-art palliative care can offer. Participants who in other respects held very different views concurred as well that patients may be vulnerable to coercion, particularly patients who are in other ways disadvantaged; and expressed concern in common that forces external to medicine could adversely influence practice.

These are much the same concerns the Institute of Medicine identified in its 2015 report, Dying in America [22]. They are concerns echoed in a February 2018 workshop on physician-assisted death convened by the National Academies of Science, Engineering and Medicine [23]. They underscore how important it is to understand why a patient requests assisted suicide as a starting point for care.

Patient requests for assisted suicide invite physicians to have the kind of difficult conversations that are too often avoided. They open opportunities to explore the patient’s goals and concerns, to learn what about the situation the individual finds intolerable and to respond creatively to the patient’s needs other than providing the means to end life—by such means as better managing symptoms, arranging for psychosocial or spiritual support, treating depression, and helping the patient to understand more clearly how the future is likely to unfold [4,24]. Medicine as a profession must ensure that physicians are skillful in engaging in these difficult conversations and knowledgeable about the options available to terminally ill patients [25]. The profession also has a responsibility to advocate for adequate resources for end-of-life care [14,25], particularly for patients from disadvantaged groups. The availability of assisted suicide where it is legal must not be allowed to interfere with excellent care at the end of life.
CONCLUSION

At the core of public and professional debate, the council believes, is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient’s deepest self-defining beliefs and in the presence of trusted companions, including where feasible and when the patient desires, the presence of a trusted physician. As Timothy Quill noted more than 20 years ago, “dying patients do not have the luxury of choosing not to undertake the journey, or of separating their person from their disease” [24]. Decisions about how to approach the end of life are among the most intimate that patients, families, and their physicians make. Respecting the intimacy and the authenticity of those relationships is essential if our common ideal is to be achieved.

RECOMMENDATION

Over the past two years, the Council on Ethical and Judicial Affairs has reviewed the literature and received thoughtful input from numerous individuals and organizations to inform its deliberations, and is deeply grateful to all who shared their insights. CEJA engaged in extensive, often passionate discussion about how to interpret the Code of Medical Ethics in light of ongoing debate and the irreducible differences in moral perspectives identified above. After careful consideration, CEJA concludes that in its current form the Code offers guidance to support physicians and the patients they serve in making well-considered, mutually respectful decisions about legally available options for care at the end of life in the intimacy of a patient-physician relationship. The Council on Ethical and Judicial Affairs therefore recommends that the Code of Medical Ethics not be amended, that Resolutions 15-A-16 and 14-A-17 not be adopted and that the remainder of the report be filed.

Fiscal Note: None.
REFERENCES


24. Quill TE. Doctor, I want to die. will you help me? *JAMA* 1993;270:870–873.
At its 1984 Interim Meeting, the House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) policy database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

• Each year the House policies that are subject to review under the policy sunset mechanism are identified.
• Policies are assigned to appropriate Councils for review.
• For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) sunset the policy; (c) retain part of the policy; d) reconcile the policy with more recent and like policy. A justification must be provided for the recommended action to retain a policy.
• A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. A reaffirmation or amendment to policy by the House of Delegates resets the sunset clock, making the reaffirmed or amended policy viable for another 10 years.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.
2008 POLICIES

In this report, the Council on Ethical and Judicial Affairs presents its recommendations regarding the disposition of 2008 House policies that were assigned to or originated from CEJA.

DUPLICATIVE POLICIES

On the model of the Council on Long Range Planning & Development (CLRPD)/CEJA Joint Report I-01 and of subsequent reports of CEJA’s sunset review of House policies, this report recommends the rescission of House policies issued since June 2008. As noted previously, the intent of this process is the elimination of duplicative ethics policies from PolicyFinder. The process does not diminish the substance of AMA policy in any sense. Indeed, CEJA Opinions are a category of AMA policy.

MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

The Council continues to present reports to the HOD. If adopted, the recommendations of these reports continue to be recorded in PolicyFinder as House policy. After the corresponding CEJA Opinion is issued, CEJA utilizes its annual sunset report to rescind the duplicative House policy.

For example, at the 2007 Interim Meeting, the HOD adopted the recommendations of CEJA Report 8-I-07, “Pediatric Decision-Making.” It was recorded in PolicyFinder as Policy H-140.865. At the 2008 Annual Meeting, CEJA filed the corresponding Opinion E-2.026, thereby generating a duplicative policy. Under the mechanism to eliminate duplicative ethics policies, CEJA recommended the rescission of Policy H-140.865 as part of the Council’s 2009 sunset report.

The Appendix provides recommended actions and their rationale on House policies from 2008, as well as on duplicate policies.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500.
## APPENDIX - RECOMMENDED ACTIONS

<table>
<thead>
<tr>
<th>Policy No.</th>
<th>Title</th>
<th>Recommended Action &amp; Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-160.998</td>
<td>Health Care Dignity and Self Respect</td>
<td>Rescind: Policies have been superseded by the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="https://www.ama-assn.org/physician-resources/system-reform">H-165.888 Evaluating Health System Reform Proposals</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="https://www.ama-assn.org/practice-management/health-insurance">H-165.920 Individual Health Insurance</a></td>
</tr>
<tr>
<td>H-230.962</td>
<td>Subspecialists Functioning as Primary Care Physicians</td>
<td>Retain: Policy remains relevant; edit to remain timely</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It is the policy of the AMA that clinical privileges in primary care be granted to physicians that have demonstrated capability through education, training, experience and current competence, and that the practice of managed care organizations to arbitrarily deny denying primary care privileges to physicians because of subspecialty or second specialty training be opposed by the AMA.</td>
</tr>
<tr>
<td>H-315.981</td>
<td>Privacy of a Physician's Personal Medical Records</td>
<td>Retain: Policy remains relevant.</td>
</tr>
<tr>
<td>H-35.999</td>
<td>Medicine and Pharmacy Relations</td>
<td>Retain: Policy remains relevant.</td>
</tr>
<tr>
<td>H-350.971</td>
<td>Initiatives Regarding Minorities</td>
<td>Defer recommendation to 2018 Interim meeting pending report on consolidation of AMA policy addressing issues of disparities and the health of minority populations:</td>
</tr>
<tr>
<td>H-350.975</td>
<td>Improving Healthcare of Hispanic Populations in the United States</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>H-160.991</td>
<td>Health Care Needs of Gay, Lesbian, Bisexual and Transgender Populations</td>
<td></td>
</tr>
<tr>
<td>H-295.878</td>
<td>Eliminating Health Disparities—Promoting Awareness and Education of Lesbian, Gay, Bisexual and Transgender (LGBT) Issues in Medical Education</td>
<td></td>
</tr>
<tr>
<td>H-350.957</td>
<td>Addressing Immigrant Health Disparities</td>
<td></td>
</tr>
<tr>
<td>H-350.958</td>
<td>Hispanic Population and Access to the US Healthcare System</td>
<td></td>
</tr>
<tr>
<td>H-350.959</td>
<td>Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities</td>
<td></td>
</tr>
<tr>
<td>H-350.961</td>
<td>Improving the Health of Minority Populations</td>
<td></td>
</tr>
<tr>
<td>H-350.966</td>
<td>Health Initiatives on Asian-Americans and Pacific Islanders</td>
<td></td>
</tr>
<tr>
<td>H-350.971</td>
<td>AMA Initiatives Regarding Minorities</td>
<td></td>
</tr>
<tr>
<td>H-350.972</td>
<td>Improving the Health of Black and Minority Populations</td>
<td></td>
</tr>
<tr>
<td>H-350.974</td>
<td>Racial and Ethnic Disparities in Health Care</td>
<td></td>
</tr>
<tr>
<td>H-350.976</td>
<td>Improving Health Care of American Indians</td>
<td></td>
</tr>
<tr>
<td>H-440.869</td>
<td>Establishment of State Commission/Task Force to Eliminate Racial and Ethnic Health Care Disparities</td>
<td></td>
</tr>
<tr>
<td>D-350.996</td>
<td>Strategies for Eliminating Minority Health Care disparities</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Action</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>H-350.978</td>
<td>Minorities in the Health Professions</td>
<td>Retain: Policy remains relevant.</td>
</tr>
<tr>
<td>H-370.967</td>
<td>Ethical Procurement of Organs for Transplantation</td>
<td>Retain: Policy remains relevant.</td>
</tr>
<tr>
<td>H-375.965</td>
<td>Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations</td>
<td>Retain: Policy remains relevant.</td>
</tr>
<tr>
<td>H-375.969</td>
<td>Physician Access to Performance Profile Data</td>
<td>Retain: Policy remains relevant.</td>
</tr>
<tr>
<td>H-375.970</td>
<td>Professional Review Organization Peer Review</td>
<td>Retain: Policy remains relevant.</td>
</tr>
<tr>
<td>H-405.999</td>
<td>Physicians in Public Affairs</td>
<td>Retain: Policy remains relevant.</td>
</tr>
<tr>
<td>H-465.988</td>
<td>Educational Strategies for Meeting Rural Health Physician Shortage</td>
<td>Retain: Policy remains relevant.</td>
</tr>
<tr>
<td>H-465.994</td>
<td>Committee on Rural Health</td>
<td>Retain: Policy remains relevant; revise title for clarity “Improving Rural Health Care”</td>
</tr>
<tr>
<td>H-475.987</td>
<td>Freedom of Speech in Medical Information</td>
<td>Rescind: Policy addresses litigation concluded in 1997 and is outdated.</td>
</tr>
<tr>
<td>D-478.992</td>
<td>Health Information Technology Purchasing Guidance</td>
<td>Rescind: Directive is accomplished through extensive resources available online at: <a href="https://www.ama-assn.org/practice-management/improving-digital-health">https://www.ama-assn.org/practice-management/improving-digital-health</a></td>
</tr>
</tbody>
</table>

D-55.997 Cancer and Health Care Disparities among Minority Women
D-65.995 Health Care Disparities among Gay, Lesbian, Bisexual and Transgender Families
Whereas, President Trump’s administration has created a new conscience and religious freedom division within the Health and Human Services department, with the intent of allowing all health professionals to opt out of providing services that violate their moral or religious beliefs; and

Whereas, The Acting Health and Human Services Secretary Eric D. Hargan has stated that the creation of this office, “represents a rollback of polices that had prevented many Americans from practicing their profession and following their conscience at the same time, and that Americans of faith should feel at home in our health system, not discriminated against, and that states should have the right to take reasonable steps in overseeing their Medicaid programs, and being good stewards of public funds”; and

Whereas, A number of women’s groups, LGBT rights groups and physicians have expressed that the creation of this office and policy would further discriminate against vulnerable populations and worsen inequities within the health care system; and

Whereas, To impose a broad religious refusal policy that will allow individuals and institutions to deny basic care for women, transgender people and people of diverse ethnic backgrounds; and

Whereas, This policy reverses years of policies that have been put in place under previous administrations that had narrowed conscience protections; and

Whereas, This new office and policy appears to go against the oath that health care providers take when they enter their professions, to provide basic care to those who need it; and

Whereas, The MSSNY Committee on Health Disparities believes that religious liberty gives a person the right to their beliefs, but it does not give a person the right to impose those beliefs on others, or harm others, including by discriminating against others; therefore be it

RESOLVED, That our American Medical Association speak against policies that are discriminatory and create even greater health disparities in medicine (Directive to Take Action); and be it further

RESOLVED, That our AMA be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (Directive to Take Action)
RELEVANT AMA POLICY

Racial and Ethnic Disparities in Health Care H-350.974
1. 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.
2. The AMA emphasizes three approaches that it believes should be given high priority:
   A. 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.
   B. 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.
   C. 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.
3. 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.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Whereas, The Family and Medical Leave Act (FMLA) requires employers with 50 or more employees to grant up to 12 weeks of unpaid annual leave to allow workers to care for a spouse, child, or parent (except in-laws) with a serious health condition, to take leave for personal health conditions, or to care for newly born or adopted children;¹ and

Whereas, LGBT persons report poorer health as compared to their heterosexual counterparts, including earlier age at disability, increased risk of sexually transmitted infection among MSM, decreased likelihood to obtain preventive cervical cancer screening among lesbian women, and increased incidence of obesity among lesbian and bisexual women;² ³ ⁴ ⁵ and

Whereas, Results from the 2008 National Health Interview Survey indicated workers with paid leave are significantly more likely to see healthcare providers and to receive preventative screenings independent of insured or uninsured status and health status;⁶ and

Whereas, In 2016, a study from the American Journal of Orthopsychiatry asserted that affirming the chosen family of LGBT individuals in family and medical leave policies improved mental well-being;⁷ and

Whereas, In 2010, the United States Office of Personnel Management issued regulations to modify its definitions of family member and immediate relative to include “domestic partner and parents thereof” and “any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship” in order to expand the categories of individuals for whom an employee may use leave;⁸ and

Whereas, Arizona⁹, the District of Columbia¹⁰, Hawaii¹¹, Maine¹², New York¹³, and Oregon¹⁴ have expanded upon the federal FMLA regulations in favor of the “blood or affinity” model,

⁸ 75 FR § 33491 – Absence and Leave; Definitions of Family Member, Immediate Relative, and Related Terms. 2010.
¹⁰ D.C. Code § 32-501(4)
¹¹ N.Y. Workers’ Comp. Law §§ 4; 201(20)
¹³ Wis. Stat. Ann. §§ 103.10(1)(ar); 40.02(21c)-21(d)
¹⁴ D.C. Code Ann. § 32-131.01(C)
which allows FMLA-equivalent benefits for chosen family, domestic partners, and individuals who are dependent or mutually interdependent on the employed individual; therefore be it

RESOLVED, That our American Medical Association advocate that Family and Medical Leave Act policies include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY:

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.
Res. 05, A-16

Health Care Disparities in Same-Sex Partner Households H-65.973
Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families D-65.995
Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children.
Whereas, The Health Insurance Portability and Accountability Act (HIPAA) placed “limitations on
the sale of medical information to third parties for marketing purposes” and prevents medical
information from being disclosed unless permitted or required;¹,²,³ and

Whereas, Secondary use of health data entails the use of protected health information (PHI)
outside of direct healthcare delivery including strictly commercial activities;¹ and

Whereas, Under HIPAA, patient consent is not required to use and disclose PHI for treatment,
payment, and healthcare operations (TPO); meanwhile, patient authorization is required when
“voluntary consent is not sufficient to permit a use or disclosure of protected health information”
which largely consists of any use outside of TPO, unless an exception applies;⁴ and

Whereas, HIPAA does not apply after data is de-identified nor does it prohibit selling or sharing
of de-identified data without prior patient authorization for “research, public health, law
enforcement, judicial proceedings, and other ‘public interest and benefit activities’”;²,⁵,⁶,⁷,⁸ and

Whereas, The extent to which patient data collection and use for purposes not directly related to
patient care and public health such as for pure commercial intent is not well understood or
regulated;⁹,¹⁰ and

Whereas, A multimillion-dollar industry has been established based on sales of patient health-
related information;¹⁰ and

Whereas, In US courts, transactions involving de-identified patient data irrespective of their
purpose have come to be labeled as expressions of free speech;¹¹,¹² and

¹Department of Health and Human Services. Summary of the HIPAA Security Rule. Health Information Privacy. https://www.hhs.gov/hipaa/for-
720X.2012.00673.x.
⁴ Department of Health and Human Services. What is the difference between “consent” and “authorization” under the HIPAA Privacy Rule? Health
Published 2013.
⁵ Cornell Law Legal Information Institute. 45 CFR 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not
§Department of Health and Human Services. May a health information organization (HIO), acting as a business associate of a HIPAA covered entity,
de-identify information and then use it for its own purposes? 2008. https://www.hhs.gov/hipaa/for-professionals/faq/544/may-a-health-information-
organization-de-identify-information/index.html.
¹² Supreme Court of the United States. WILLIAM H. SORRELL, ATTORNEY GENERAL OF VERMONT, ET AL., PETITIONERS v. IMS HEALTH INC.
Whereas, PHI ownership rights, whether it be the patient, provider, government or another
entity, is unclear and has yet to be formally settled;13 and

Whereas, As individuals continue to divulge personal information in areas outside of healthcare,
it becomes easier to consolidate data and identify those individuals in aggregated pools of
anonymized health data;3,6,14,15 and

Whereas, AMA Policy H-315.983 states that only de-identified and/or aggregate data should be
used for "business decisions," including sales, mergers, and similar business transactions when
ownership or control of medical records changes hands; and

Whereas, AMA Code of Ethics Section 3.2.4 Paragraph 2 states, “Disclosing information to third
parties for commercial purposes without consent undermines trust, violates principles of
informed consent and confidentiality, and may harm the integrity of the patient-physician
relationship”,16 and

Whereas, AMA Code of Ethics Section 3.2.4 enables the release of patient information so long
as it is de-identified and only recommends that patients be informed of the impending release
without providing patients an avenue to prevent third parties from utilizing their PHI for
commercial purposes; and

Whereas, AMA Code of Ethics Section 3.2.4 is conflicting as it emphasizes patient consent in
Paragraph 2 while Paragraph 3 immediately defers to patients only needing to be informed
about use of their de-identified information rather than providing consent; and

Whereas, AMA Code of Ethics Section 3.2.4 may conflict with HIPAA in that patient
authorization, rather than consent, is sometimes mandated for release of identifiable patient
information to third parties for reasons other than TPO; and

Whereas, A lack of accountability and transparency on how a patient’s own health data will be
used beyond their immediate care undermines both the informed consent process and the
patient-physician relationship, and impairs future efforts in healthcare, research, and public
health;6,16,17 therefore be it

RESOLVED, That our American Medical Association study the handling of de-identified patient
information and report findings and recommendations back to the AMA House of Delegates.
(Directive to Take Action)

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

Date Received: 04/26/18

RELEVANT AMA POLICY: Patient Privacy and Confidentiality H-315.983; Police, Payer, and
Government Access to Patient Health Information H-315.975; Interim Report of the Inter-Council
Task Force on Privacy and Confidentiality D-460.991Work of the Task Force on the Release of
Physician Data H-406.990; Guiding Principles, Collection and Warehousing of Electronic Medical
Record Information H-315.974

14 Committee on the Recommended Social and Behavioral Domains and Measures for Electronic Health Records; Board on Population Health and
15 Committee on the Recommended Social and Behavioral Domains and Measures for Electronic Health Records; Board on Population Health and
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-18)

Introduced by: Medical Student Section

Subject: Patient-Reported Outcomes in Gender Confirmation Surgery

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Peter H. Rheinstein, MD, JD, MS, Chair)

Whereas, There were 3200 gender confirmation surgeries performed in 2016 in the United States, which represents a 20% increase from the previous year;¹ and

Whereas, Gender confirmation surgeries include a variety of surgical procedures such as transfeminine and transmasculine genital reconstruction, breast surgery, and facial reconstruction;² and

Whereas, While numerous safe and reliable surgical options exist for patients undergoing gender confirmation surgery, there is currently no standard for patient selection and education about the various techniques available;³,⁴ and

Whereas, Patient-reported outcomes are emerging as a standard in the evaluation of and research into surgical quality and outcomes;⁵ and

Whereas, A questionnaire that assesses a patient’s perspective on their physical, sexual, and social well-being following breast reconstructive surgery has been validated for use in assessing procedure outcomes and quality;⁶ and

Whereas, Current research in gender confirmation surgery outcomes utilizes patient questionnaires related to sexual function and bowel and urinary issues that were not originally designed for the transgender population;⁷ and

Whereas, Information gathered from patient-reported outcomes could improve techniques used by surgeons, provide better training, and help new patients better understand how these operations impact overall well-being and quality of life;⁸ therefore be it

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

RESOLVED, That our AMA support development and implementation of standardized tools, such as questionnaires to evaluate outcomes of gender confirmation surgeries. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.
Citation: Res. 122; A-08; Modified: Res. 05, A-16;
See also:
- H-160.991 Health Care Needs of Lesbian Gay Bisexual and Transgender Populations
- H-460.907 Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients
- D-345.994 Increasing Detection of Mental Illness and Encouraging Education
Whereas, Numerous studies have demonstrated the widespread existence of sex and gender bias and disparities in the provision and outcomes of health care, and that awareness of gender bias does not negate its effect;1,2,3,4,5,6,7,8 and

Whereas, These disparities have been attributed to provider bias, physiologic and pathophysiologic sex differences, or a combination of both;1,4,9,10 and

Whereas, Patients with a feminine gender identity or presentation are at risk for gender-bias in health care regardless of biological sex,6,8 and

Whereas, Gender disparities exist in treatments, invasive therapies, referral patterns and wait times which often leads to worsened outcomes including increased mortality rates;1-4,6 and

Whereas, Clinical Decision Support (CDS) tools, which provide electronic alerts and computerized order sets, are recognized methods to minimize gender bias and decrease disparities through automatization of treatment and diagnostic protocols;10,11,12,13,14 and

---

Whereas, The AMA’s Commission to End Health Care Disparities sought “to ensure equitable, appropriate, effective, safe, and high quality care for all, with no gaps in services based on any medically irrelevant factor;” yet conclusions from the Commission refer only to racial and ethnic disparities;¹⁵ and

Whereas, The Council on Ethical and Judicial Affairs recommended in 1991 encouraging the development and implementation of procedures and techniques that preclude or minimize the negative impact of gender bias;¹³ and

Whereas, A 2016 report from the AMA’s Council on Science and Public Health acknowledged both biological and social factors leading to disparities in women’s health, but only suggested improving medical education and including women in clinical research as solutions;¹⁴ and

Whereas, The AMA has existing policy declaring a commitment to eliminating health care disparities with a specific mention of racial and ethnic health disparities, but does not have a policy directly targeting gender-based health care disparities;¹² therefore be it

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

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

Fiscal note: Minimal - less than $1,000.

Received: 04/26/17

RELEVANT AMA POLICY

D-478.995 National Health Information Technology
H-350.971 AMA Initiatives Regarding Minorities
D-350.995 Reducing Racial and Ethnic Disparities in Health Care
An Expanded Definition of Women's Health H-525.976
Medical Education and Training in Women's Health H-295.890
Sex and Gender Differences in Medical Research H-525.988
8.5 Disparities in Health Care
Principles of the Patient-Centered Medical Home H-160.919
Medicare Physician Payment Reform D-390.961
Whereas, Living donor organ transplantation is often the best and most cost effective treatment option for patients with end stage organ failure; and

Whereas, Living organ donors have faced discrimination in obtaining life, disability, and long-term care insurance due to company policy prohibitions, coverage denial, or premium price increases; and

Whereas, Clarification is needed regarding live organ donation surgery in qualifying as a serious health condition under the Family Medical Leave Act; and

Whereas, Educational materials on the benefits of live organ donation are not universally available; and

Whereas, The “Living Donor Protection Act of 2017” (HR 1270) addresses each of these burdens related to living organ donation; and

Whereas, Transplant professional and patient-centered organizations have publicly supported the Living Donor Protection Act of 2017; therefore be it

RESOLVED, That our American Medical Association strongly and actively support the Living Donor Protection Act of 2017 (HR 1270). (Directive to Take Action)


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

Received: 04/27/18
Whereas, Self-induced abortion involves women attempting to induce abortion without medical assistance; and

Whereas, Laws criminalizing self-induced abortion increase health risks and deter patients from seeking necessary healthcare services related to self-induced abortion or miscarriage; and

Whereas, Laws criminalizing patients who self-induce abortion lead to increased suspicion towards patients presenting to healthcare providers for miscarriage; and

Whereas, From the beginning of 2011 through July 2016, states enacted 334 new legal restrictions on abortion, further limiting access to abortion care. In 2018 alone, 695 provisions have already been introduced to further restrict abortion; and

Whereas, National studies of abortion patients have shown that approximately 2% of patients attempted to self-induce an abortion at some point in their lives. That number is higher in states such as Texas with stricter legal restrictions on abortion, where one study showed that 7% of patients attempted some method to end their pregnancy before presenting to the clinic; and

Whereas, Google search trends from 2005 and 2015 have shown a relative increase in searches for self-induced abortion that correlate with state-based abortion restrictions; and

Whereas, There were more than 700,000 Google searches looking into self-induced abortions in 2015; and

Whereas, A recent online study of 1,235 people who google searched “self-abortion” revealed that almost three-quarters (73%) indicated that they were searching for information because they were pregnant and did not or may not want to be; and

Whereas, Self-induced abortion is significantly associated with post-abortion complications, maternal morbidity and mortality; and

Whereas, The ability and willingness to access medical care if complications relating to self-induced abortion arise are essential for patient safety; and

Whereas, People of color are disproportionately targeted for prosecution and criminalization related to pregnancy outcomes; and
Whereas, The American College of Obstetricians and Gynecologists (ACOG) has taken a very strong position that women should not be prosecuted for trying to end their own pregnancies. ACOG additionally opposes forcing physicians to share information about patients due to its burdensome interference in the patient-provider relationship; therefore be it

RESOLVED, That our American Medical Association oppose the criminalization of self-induced abortion as it increases patients’ medical risks and deters patients from seeking medically necessary services (New HOD Policy); and be it further

RESOLVED, That our AMA advocate against any legislative efforts to criminalize self-induced abortion. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 05/01/18

References:
3. Ibid.

Relevant AMA Policy:
Right to Privacy in Termination of Pregnancy H-5.993
Pregnancy Termination H-5.983
Opinion 4.2.7 Abortion
H-5.995 Abortion
H-160.946 The Criminalization of Health Care Decision Making
Introduced by: Women Physicians Section

Subject: Health Care Rights of Pregnant Minors

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Peter H. Rheinstein, MD, JD, MS, Chair)

Whereas, Some states require parental consent or parental notice for pregnant minors to receive prenatal care tests and procedures such as prenatal genetic testing, epidural block and cesarean section; and

Whereas, In some cases, states allow only certain groups of minors--such as those who are married or already parents--to consent to related prenatal care tests and procedures; and

Whereas, Four states (Kansas, Nevada, New Hampshire, West Virginia) allow a minor who is considered “mature” to consent to related prenatal care tests and procedures; and

Whereas, One state (North Dakota) allows a minor to consent to prenatal care during the first trimester while requiring parental consent for prenatal care during the second and third trimesters; and

Whereas, Thirteen states (Arizona, Connecticut, Indiana, Iowa, Louisiana, Maine, Nebraska, Ohio, Rhode Island, South Dakota, Vermont, Wisconsin, and Wyoming) have no relevant policy or case law regarding minors’ authority to consent to prenatal care; and

Whereas, In some states, such as Indiana and Ohio, without relevant policy or case law, people under age 18 who are in labor cannot consent to their own health care or anything considered to be elective, such as an epidural block; and

Whereas, An epidural block is the most common type of pain relief used for childbirth in the United States; and

Whereas, There are reports of parents withholding consent for interventions such as epidural blocks as a form of punishment for minors becoming pregnant; and

Whereas, Current AMA policy does not oppose restrictions on consent-related rights; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders to support legislation allowing pregnant minors to consent to related tests and procedures from the prenatal stage through postpartum care (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose any law or policy that prohibits a pregnant minor to consent to prenatal and other pregnancy related care, including, but not limited to, prenatal genetic testing, epidural block, and Cesarean section. (Directive to Take Action)
Fiscal note: Modest - between $1,000 - $5,000.

Received: 05/01/18

References:
4. Medications for Pain Relief during Labor and Delivery. Available at https://www.acog.org/Patients/FAQs/Medications-for-Pain-Relief-During-Labor-and-Delivery#what.

Relevant AMA Policy:

Confidential Health Services for Adolescents H-60.965

Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

Citation: (CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, I-14)

See also:
2.2.1 Pediatric Decision Making
2.2.2 Confidential Health Care for Minors
Whereas, In recent years our AMA has affirmed the medical relevance of induced abortion; and

Whereas, There are several AMA policies that are directly or indirectly related to induced abortion; and

Whereas, Amendments and revisions of policies have sometimes resulted in use of imprecise and inconsistent language; and

Whereas, This may result in inaccurate perceptions, and reporting of AMA policies on induced abortion; and

Whereas, A review of these policies reveals language inconsistencies that cause AMA policy misunderstandings by the public, as evidenced in the need for and premise for policy H-5.988, “Accurate Reporting on AMA Abortion Policy”; and

Whereas, Legal induced abortion is defined by the Centers for Disease Control and Prevention (CDC), for the purpose of CDC surveillance, as an intervention performed by a specially trained and licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, or physician assistant) that is intended to terminate an ongoing pregnancy; and

Whereas, The AMA has previously only recognized abortion performed by duly licensed physicians; and

Whereas, In certain states, other licensed and specially trained clinicians perform abortion; and

Whereas, The American College of Obstetricians and Gynecologists encourages expanding the trained pool of non-obstetrician-gynecologist providers to include family physicians, nurse practitioners, physician assistants, and certified nurse-midwives, thereby supporting access to safe abortion care; and

Whereas, Clinical evidence suggests that outcomes are equivalent between physician and other trained clinicians; therefore be it

RESOLVED, That our American Medical Association review its policies on abortion to ensure use of appropriate terminology and that such policies are reflective of appropriate practice standards (Directive to Take Action); be it further
RESOLVED, That AMA Policy H-5.988, “Accurate Reporting on AMA Abortion Policy,” be amended by addition to read as follows:

Accurate Reporting on AMA Abortion Policy H-5.988

Our AMA House of Delegates (HOD) cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates HOD to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy.

(Ammend HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 05/01/18

References:

RELEVANT AMA POLICY

Accurate Reporting on AMA Abortion Policy H-5.988

Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy.

Citation: (Sub. Res. 21, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)

Pregnancy Termination H-5.983

The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO).

Citation: (Res. 520, A-95; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient; (2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship; (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and (4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

Citation: (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)

See also: Policy on Abortion H-5.990; Right to Privacy in Termination of Pregnancy H-5.993; Abortion H-5.995; E-4.2.7 Abortion; E-4.1.2 Genetic Testing for Reproductive Decision Making
WHEREAS, Recent data demonstrate that significant differences in salary and compensation exist between male and female physicians, despite improvements in explicit gender discrimination; and

WHEREAS, Women physicians in academic medicine and in practice earn less than men even after adjustment for factors such as age, years of experience, specialty, reported work hours, clinical productivity, research productivity, and faculty rank; and

WHEREAS, A recently published analysis of salary differences at 24 US public medical schools found that the annual salaries of female physicians were $19,879 (8%) lower than the salaries of male physicians; this difference persisted through all faculty ranks; and

WHEREAS, This gender compensation gap is likely to only widen over the course of a woman’s career; and

WHEREAS, Explicit gender bias in academic medicine has largely decreased since the passage of the Education Amendment to the Civil Rights Act (Title IX), however implicit biases persist and cultural stereotypes continue to disadvantage women in male dominated fields; therefore be it

RESOLVED, That our American Medical Association advocate for institutional and departmental policies that promote transparency in defining the criteria for initial and subsequent physician compensation (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for equal base pay based on objective criteria (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for implicit bias and compensation determination training for those in positions to determine salary and bonuses, with a focus on how subtle differences in the evaluation of male and female physicians may impede compensation and career advancement (New HOD Policy); and be it further

RESOLVED, That our AMA encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians (New HOD Policy); and be it further

RESOLVED, That our AMA establish educational programs to help empower all genders to negotiate equitable compensation. (Directive to Take Action)
Fiscal Note: Not yet determined

Received: 05/01/18


RELEVANT AMA POLICY

Gender Disparities in Physician Income and Advancement D-200.981

Our AMA:

(1) encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;
(2) supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;
(3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;
(4) will collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and
(5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

Citation: (BOT Rep. 19, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13)
Whereas, The American Medical Association and AMA's Women Physicians Section have made concerted efforts to highlight the disparity of physician payment by gender in the United States today, and to increase the influence of women physicians in leadership roles in medicine;¹ and

Whereas, In 2015, while women comprised 34% of the active physician workforce in the United States, and an estimated 46% of all physicians-in-training as well as more than half of all medical students are women, much remains to be done to improve equity and parity among physician payment and to increase opportunities for promotion and leadership;² and

Whereas, Studies have historically found a payment disparity gap among male and female physicians within the same specialty,³ and this payment disparity continues to exist in all specialties of medicine in 2018;⁴ and

Whereas, Among cohorts of equal training and experience, adjusting for variables including workhours, calls, vacation, gender, academic versus non-academic practice, women held less advanced academic positions, earning significantly less compensation ten years after graduation;⁵ and

Whereas Significant differences in salary also exist among male and female physicians with faculty appointments at U.S. public medical schools, even after accounting for age, experience, specialty faculty rank, and measures of research productivity and clinical revenue;⁶ and

Whereas, Female physicians in early and mid-career may opt for flexibility in schedules in their child-bearing and child-rearing years; and

Whereas, The U.S. will face a significant shortage of physicians, fueled by population growth, an increase in the number of aging Americans, and retirement of practicing doctors, a shortage of between 40,800 and 104,900 physicians by 2030⁷, and the AMA has prioritized confronting this shortage in previous AMA House of Delegates meetings;⁸ and

Whereas, The city of Chicago can no longer ask about salary history on employment applications, part of a growing effort nationwide to improve pay equality between men and women;⁹ and

Whereas, On January 29, 2009 the Lilly Ledbetter Fair Pay Act was signed into law to reinforce the protection against pay discrimination under the Equal Pay Act of 1963 (EPA), which prohibits sex-based wage discrimination between men and women in the same establishment
who perform jobs that require substantially equal skill, effort, and responsibility under similar working conditions; therefore be it

RESOLVED, That our American Medical Association, together with the assistance of professional medical societies, create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act (Directive to Take Action); and be it further

RESOLVED, That our AMA, together with the assistance of professional medical societies, help U.S. public medical schools and facilities create guidance for institutional transparency of compensation, and regular gender-based pay audits, in order to narrow the gender inequity in pay and promotion (Directive to Take Action); and be it further

RESOLVED, That our AMA recommend to eliminate the question of prior salary information from job applications for physician recruitment in academic and private practice. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/02/18

---

1 American Medical Association: https://www.ama-assn.org/about/women-physicians-section-wps

RELEVANT AMA POLICY

Gender Disparities in Physician Income and Advancement D-200.981
Our AMA:
(1) encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;
(2) supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;
(3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;
(4) will collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and
(5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.
Citation: (BOT Rep. 19, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13)

See also: E-9 5.5 Gender Discrimination in Medicine; Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Resolved, That our American Medical Association seek legislation to ensure that living kidney donors are reimbursed for expenses associated with donation of their kidney. (Directive to Take Action)

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

Received: 05/02/18
Whereas, Differences of sex development (DSD), also known as intersex, are defined as congenital development of ambiguous genitalia (e.g., 46,XX virilizing congenital adrenal hyperplasia), congenital disjunction of sex anatomy (e.g., Complete Androgen Insensitivity Syndrome), incomplete development of sex anatomy (e.g., gonadal agenesis), sex chromosome anomalies (e.g., Turner Syndrome), and disorders of gonadal development (e.g., ovotestes); and

Whereas, Sex (the biological state of being male or female), gender (a person’s self-representation as male or female), and sexual orientation (direction(s) of erotic interest -- heterosexual, bisexual, homosexual) are three separate categories existing on a spectrum; and

Whereas, For many decades research has supported the idea that our experience of our bodies and gender identity is inherent in us and not something that can be assigned; and

Whereas, DSD is currently presented as a pathological condition requiring medical attention rather than biological variance outside of the hegemonic sex binary; and

Whereas, There is little research on the incidence of DSD, but estimates range from 1 in 5000 ambiguous genitalia to 1 in 1,500 for atypical genitalia; and

Whereas, The frequency of DSD from 1955 to 2000 was estimated to be as high as 2 percent of live births worldwide; and the frequency of individuals receiving corrective genital surgery was estimated to be 0.1-0.2 percent of all live births; and

Whereas, No straightforward recommendations exist in the U.S. for sex assignment in Neonates with DSD; however, there is a growing consensus that any surgical intervention in neonates and infants leading to irreversible changes should be done with the utmost caution; and

Whereas, The majority of reconstructive surgeries for DSD in the U.S. are typically performed during the first year; however, this timing is controversial and there is limited data on the long term psychological outcomes for patients; and

Whereas, A survey of young adults found that 93 percent of women would not have wanted their parents to agree to a genitoplasty surgery for an enlarged clitoris unless the condition were life threatening and almost all men would not have wanted sex reassignment for a micropenis if it might have impacted their sexual pleasure; and
Whereas, Medical professionals (including three former U.S. Surgeons General: Doctor Joycelyn Elders, Doctor David Satcher, and Doctor Richard Carmona) as well as national organizations such as United Nations, Amnesty International and Human Rights Watch have recommended against and are devoted to ending unnecessary surgeries on infants with DSD\textsuperscript{11,19,20,21}; and

Whereas, The human rights organization Amnesty International documented numerous examples of human rights violations during instances of "invasive and irreversible 'normalizing' surgeries" for children with DSD\textsuperscript{21}; and

Whereas, The 2015 European Union Report on the current legal state of affairs regarding intersex rights of member states found that at least 18 member states legally require patient (rather than parental) consent for surgical intervention in DSD\textsuperscript{22}; and

Whereas, Medically unnecessary DSD surgery is defined as, "all surgical procedures that seek to alter the gonads, genitals, or internal sex organs of children with atypical sex characteristics too young to participate in the decision, when those procedures both carry a meaningful risk of harm and can be safely deferred"\textsuperscript{18}; and

Whereas, The court case \textit{MC v. Aaronson}, concerning the potential violation of constitutional rights of a person who underwent intersex genital mutilation without consent at age one while a ward of the state, was later dismissed by the Court of Appeals for the Fourth Circuit since there was "no fair warning to those involved in the decision regarding M.C.'s surgery that they were violating his clearly established constitutional rights;"\textsuperscript{23} and

Whereas, There are minimal studies examining the long-term impact of these surgeries, but those studies found that persons with DSD that did not have surgical intervention as infants primarily experienced psychological stress from feelings of isolation from other individuals, communities, and support groups, rather than from the absence of early surgical intervention\textsuperscript{11,24}; and

Whereas, Attempting to alter a person’s sexual identity or sexual orientation through any type of therapy may cause psychological harm\textsuperscript{25}; and

Whereas, Chronic juvenile stress has been associated with the development of neuropsychiatric illness in adulthood; much like the stress caused by having one’s biological sex assigned for them at birth\textsuperscript{26}; and

Whereas, Permanent alterations to genitalia before a patient can consent may result in the child being assigned a gender incongruent with their gender identity and lead to adverse outcomes including loss of sensitivity, orgasmic function, and fertility\textsuperscript{2,12,27}; therefore be it

RESOLVED, That our American Medical Association oppose the assignment of gender binary sex to infants with differences in sex development through surgical intervention outside of the necessity of physical functioning for an infant and believes children should have meaningful input into any gender assignment surgery. (New HOD Policy)

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

Received: 05/02/18
Whereas, The LGBTQ+ (per the Urban Dictionary – lesbian, gay, bisexual, transgender, questioning and + meaning other sexualities such as pansexual, asexual and omnisexual extra) population in the United States is estimated to be over 10 million people (4.1 percent of the population); and

Whereas, LGBTQ+ populations are vulnerable and often marginalized in society and in the medical system; and

Whereas, LGBTQ+ focus groups have established that distinguishing their identity within the medical system is often a source of great discomfort; and

Whereas, LGBTQ+ focus groups have also identified normalization of their gender identities as a major component of their recommendations to improve health care experiences; and

Whereas, Intake forms in medical facilities (i.e., clinics, hospitals) often have only binary gender options, and only 5 percent of forms are gender inclusive in able to identify transgender patients; and

Whereas, The Institute of Medicine recommends the collection of data on sexual orientation and gender identity as part of the electronic health record, but 14 percent of intake forms confuse gender and sexual orientation; and

Whereas, An LGBTQ+ friendly intake form establishes a comfortable and welcoming atmosphere for the LGBTQ+ patient in the office; and

Whereas, The Gay and Lesbian Medical Association offers various guidelines for improving the care of LGBTQ+ patients, including the use of gender-neutral forms; and

Whereas, Twenty-four percent of transgender and gender nonconforming patients reported denial of equal treatment in the while seeking healthcare; and

Whereas, The American Medical Association has an established stance on and commitment to the ongoing improvement of nonjudgmental, nondiscriminatory, and culturally competent care of LGBTQ+ patients; therefore be it

RESOLVED, That our American Medical Association distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, “Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation,” to our membership. (Directive to Take Action)
Fiscal Note: Not yet determined

Received: 05/02/18

RELEVANT AMA POLICY

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17;

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

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

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

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

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

Citation: CSA Rep. C, I-81; Reaffirmed: CLRDP Rep. F, I-91; CSA Rep. 8-I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17;
Whereas, The United Nations has defined human trafficking as “the recruitment, transportation, transfer, harboring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, or deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, as a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs;” and

Whereas, All 50 states have enacted laws criminalizing human trafficking activities; and

Whereas, AMA Board of Trustee Report 20, A-13, encourages its member groups and sections as well as the Federation of Medicine, to raise awareness about human trafficking and of resources available to help them identify and address the needs of victims; and

Whereas, The Polaris Project operates a 24-hour national human trafficking hotline which also provides assessment tools for healthcare professionals and on-line training; and

Whereas, Current AMA Policy H-65.966 will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim’s medical, legal, and social needs; and

Whereas, The January 2017 American Medical Association Journal of Ethics featured numerous perspectives on how physicians can respond for effectively to this vulnerable population and has brought awareness; and

Whereas, According to the US Department of State, Human Trafficking is the fastest growing criminal activity in the world, second only to drug trafficking. This modern-day slavery generates over $150 billion annually for organized crime; and

Whereas, Human trafficking continues to be an increasing substantial societal problem in Oklahoma and nationally; and

Whereas, Physicians are first responders in this epidemic and their education has been underwhelming compared to the rate of increase of this problem; and

Whereas, Health care providers are key stakeholders in the abolitionist movement. An estimated 28% of trafficked persons encounter the health care system while in captivity but
virtually none are ever detected. Only 1 in 100 trafficked victims are ever rescued. Recognizing red flags is absolutely essential. Without an awareness of human trafficking, victims will continue to go undetected by health care professionals; therefore be it

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

Fiscal Note: Not yet determined

Received: 05/01/18

References
- Human Trafficking Into and Within the United States: A Review of the Literature. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

RELEVANT AMA POLICY

Physicians Response to Victims of Human Trafficking H-65.966
1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.
Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.
The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.
The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
  a. An assessment tool for health care professionals
  b. Online training in recognizing and responding to human trafficking in a health care context
  c. Speakers and materials for in-person training
  d. Links to local resources across the country
The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department’s Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.
2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim’s medical, legal and social needs.

Citation: (BOT Rep. 20, A-13; Appended: Res. 313, A-15)
Reference Committee A

BOT Report(s)
40 Medicare Coverage of Services Provided by Proctored Medical Students

CMS Report(s)
01 Council on Medical Service Sunset Review of 2008 AMA House Policies
02 Improving Affordability in the Health Insurance Exchanges
03 Ensuring Marketplace Competition and Health Plan Choice
07 Insulin Affordability

Joint Report(s)
01 CMS/CSAPH Joint Report - Coverage for Colorectal Cancer Screening

Resolution(s)
101 Medicaid Reform
102 Effectiveness of Risk Assessment Models in Representing Healthcare Resources Expended for Infants and Children
103 Oppose Medicaid Eligibility Lockout
104 Emergency Out of Network Services
105 Use of High Molecular Weight Hyaluronic Acid
106 Prohibit Retrospective ER Coverage Denial
107 Opposition to Medicaid Work Requirement
108 Expanding AMA's Position on Healthcare Reform Options
109 Medicaid Coverage of Fitness Facility Memberships
110 Return to Prudent Layperson Standard for Emergency Services
111 Medicare Coverage for Dental Services
112 Enabling Attending Physicians to Waive the Three-midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs
113 Survivorship Care Plans
114 Inclusion of Bundled Payments Care Improvement (BPCI) Post-Acute only Model 3 in Advanced BPCI
REPORT OF THE BOARD OF TRUSTEES

B of T Report 40-A-18

Subject: Medicare Coverage of Services Provided by Proctored Medical Students (Resolution 812-I-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee A (Jonathan D. Leffert, MD, Chair)

At the 2017 Interim Meeting, the House of Delegates (HOD) referred Resolution 812-I-17, “Medicare Coverage of Services Provided by Proctored Medical Students,” for report back at the 2018 Annual Meeting. This resolution was introduced by the Michigan Delegation and asked that:

Our American Medical Association (AMA) amend Policy, H-390.999, “Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries,” by addition as follows:

When a physician assumes responsibility for the services rendered to a patient by a medical student, a resident, or an intern, the physician may ethically bill the patient for services which were performed under the physician’s personal observation, direction, and supervision; and

Our AMA work with the Centers for Medicare & Medicaid Services (CMS) to require coverage of medical services provided by medical students while under the physician’s personal observation, direction, and supervision.

This report provides background on payments to physicians in teaching settings and medical students providing care.

BACKGROUND

In the Guidelines for Teaching Physicians, Interns, and Residents, CMS defines a student as an individual who participates in an accredited educational program (for example, medical school) that is not an approved Graduate Medical Education (GME) program and who is not considered an intern or a resident. Medicare does not pay for any services furnished by these individuals. Specifically, CMS only reimburses for services provided by licensed physicians, which medical students are not.

In the Guidelines, CMS also states that “any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or resident in a service that meets teaching physician billing requirements.” However, CMS has clarified that, although under Medicare services by students are not billable, teaching physicians can involve students in services they perform, and to the extent that the medical student is involved in procedures under the personal supervision of a teaching physician who is performing the service, there is no prohibition against the teaching physician billing for these services. Any contribution and participation of a student in the performance of a billable service must be...
performed in the physical presence of a teaching physician or resident in service that meets
teaching physician billing requirements.

During the reference committee hearing, there was testimony from the Council on Medical
Education calling for Resolution 812 not to be adopted because of current CMS guidelines on
teaching physicians, and the current restrictions on reimbursing only for services provided by
licensed physicians.

DISCUSSION

In a teaching scenario, the teaching or supervising physician is making all of the medical decisions
and is supervising any procedures performed by the medical student. Therefore, it is logical that the
teaching or supervising physician will bill and be paid for the procedures or services. For billing
purposes, the physician must also be the individual to document the procedure, including the
medical student’s participation.

In addition, Resolution 812-I-17 raises concerns because it would allow non-licensed medical
students to bill for services. While the AMA has policy supporting payment for services rendered
to a patient by a resident or an intern, who are licensed, it would be unprecedented to include
medical students in this policy and advocate that CMS reimburse a non-licensed clinician.

Resolution 812-I-17 also raises liability concerns because it would allow physicians to bill for
services performed solely by medical students. In order to ensure physicians are not exposed to
increased liability, the AMA should not advocate that physicians be responsible for procedures that
were performed by medical students who were not overseen by a teaching or supervising physician.

Finally, adoption of Resolution 812-A-17 could blur the line between the learning environment,
where medical students pay tuition to cover the costs of being provided an education to become a
physician, and the practice environment, where licensed physicians are compensated for providing
their time and expertise educating medical students, as well as for treating patients. The Board’s
view is that these roles should remain separate.

RECOMMENDATION

The Board of Trustees recommends that Resolution 812-I-17 not be adopted and the remainder of
the report be filed.

Fiscal Note: None.

REFERENCES

Viewed on January 24, 2018 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-

2 Id.

3 University of Washington Medicine Guidance Document. Billing for Procedures when Medical Students
In 1984, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to re-establish it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House deliberations.

Modified by the House on several occasions, the policy sunset process currently includes the following key steps:

- Each year, the House policies that are subject to review under the policy sunset mechanism are identified, and such policies are assigned to the appropriate AMA Councils for review.
- Each AMA Council that has been asked to review policies develops and submits a separate report to the House that presents recommendations on how the policies assigned to it should be handled.
- For each policy under review, the reviewing Council recommends one of the following alternatives: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy.
- For each recommendation, the Council provides a succinct but cogent justification for the recommendation.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committee.

**RECOMMENDATION**

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

That our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated. (Directive to Take Action).
### Appendix

**Recommended Actions on 2008 Socioeconomic Policies**

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Policy Title</th>
<th>Recommended Action and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-70.955</td>
<td>Postoperative Care of Surgical Patients</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-70.969</td>
<td>Discriminatory Payment Polices</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-70.999</td>
<td>Diagnostic Procedural Coding System</td>
<td>Rescind. Directive accomplished. By CMS reporting mandate, this work was required to be, and in fact was, completed Oct 1, 2015. The recommendations in the policy were completed in the necessary timeframe to complete the physician roll-out of the new diagnostic code set.</td>
</tr>
<tr>
<td>D-125.995</td>
<td>Health Plan Coverage of Prescription Drugs</td>
<td>Rescind. Superseded by Policy D-120.988.</td>
</tr>
<tr>
<td>D-125.999</td>
<td>Health Plan Coverage for Over-the-Counter Drugs</td>
<td>Rescind. Superseded by Policy H-125.990.</td>
</tr>
<tr>
<td>D-155.992</td>
<td>Appropriate Hospital Charges</td>
<td>Rescind. Directive accomplished. Also superseded by Policy H-155.958, which was adopted via a 2009 Council on Medical Service report. The AMA sent a letter to the American Hospital Association with regard to the second Resolve.</td>
</tr>
<tr>
<td>D-160.944</td>
<td>Recognizing Transitions of Care for Performance Improvement</td>
<td>Rescind. Directive accomplished. The Physician Consortium for Performance Improvement (PCPI), in collaboration with the American College of Physicians, Society for Hospital Medicine, and the American Board of Internal Medicine Foundation, developed measures focusing on care transitions between the inpatient and outpatient settings. Additionally, the AMA participated in the AMDA task force to develop guidelines for transitional care in the long-term care continuum. Current guidelines are available at: <a href="https://paltc.org/product-store/transitions-care-cpg">https://paltc.org/product-store/transitions-care-cpg</a>.</td>
</tr>
<tr>
<td>D-165.959</td>
<td>State-Based Demonstration Projects to Expand Health Coverage to the Uninsured</td>
<td>Rescind. Section 1332 of the Affordable Care Act established a new waiver supporting state innovation in order to enable states to experiment with and implement different models to provide health insurance coverage to their residents, with federal pass-through funding provided. As such, superseded by Policy H-165.826.</td>
</tr>
<tr>
<td>D-165.999</td>
<td>The Impact of Rapidly Developing Biotechnology on the Delivery of Medical Care</td>
<td>Rescind. Section 2 was accomplished via AMA advocacy in support of the Affordable Care Act. Section 1 was superseded by Policies H-450.938, D-478.966, D-478.976, H-478.985, D-478.977, and D-478.991.</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
<td>Recommended Action and Rationale</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D-190.986</td>
<td>Provision of Payment Schedules and Methodology of Payment as Part of the Contracting Process</td>
<td>Rescind. Directive accomplished. The AMA added a category to the attorney expertise sheet for “Hospital Medical Staff Issues/Bylaws.” It was provided to all members of AMA. Consulting link to indicate that they have this expertise. In addition, an updated Web site allowed physicians to search for attorneys and consultants by expertise. Now any new attorney member can indicate that they have expertise in this area.</td>
</tr>
<tr>
<td>D-220.972</td>
<td>Expanding Physician and Medical Staff Participation in Accreditation Surveys</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-235.990</td>
<td>JCAHO Standard MS.1.20</td>
<td>Retain-in-part. Rescind (1) and (2), as superseded by the adoption of Standard MS.01.01.01. Amend (3[a]) as follows: Our AMA Commissioners to the Joint Commission: (1) introduce and support language before the full JCAHO board such that Standard MS.1.20 clearly states there is a single document known as the “Medical Staff Bylaws” which must be approved by the voting members of the medical staff; (2) introduce and support language before the full JCAHO board such that JCAHO Standard MS.1.20 clearly states that the following components are to be an integral part of the medical staff bylaws: a. Application, reapplication, credentialing and privileging b. Fair hearing and appeal processes c. Selection, election and removal of medical staff officers d. The clinical criteria and standards which manage quality assurance and improvement, and utilization review e. Criteria and processing for privileging f. Qualification for appointment g. The structure of the medical staff h. The duties and privileges of medical staff categories i. The right to develop and adopt medical staff policies, procedures, rules, and regulations j. The right and ability of the medical staff as a group to retain and be represented by independent legal counsel at the medical staff’s expense k. The right and ability to assess dues and to utilize the dues as the medical staff sees fit; and (3 1) continue to advocate: a. Any element of performance of Standard MS.1.20</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
<td>Recommended Action and Rationale</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>01.01.01 must be retained in the medical staff bylaws and not in other documents such as rules and regulations or policies…</strong></td>
</tr>
<tr>
<td>D-330.930</td>
<td>Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans</td>
<td>Retain-in-part. In 2010 Medicare ceased paying for CPT consultation codes. Providers now code for an evaluation and management (E&amp;M) visit when appropriate. Modify policy to read as follows: (1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation (in the inpatient setting these encounters may be reported using the follow-up consultation codes in CPT and in the outpatient setting these encounters may be reported using the appropriate office or other outpatient setting codes); and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.</td>
</tr>
<tr>
<td>D-335.984</td>
<td>Medicare Part B Contractor Changes</td>
<td>Rescind. Directive accomplished. AMA staff was in regular contact with CMS to address persistent and ongoing problems with Part B contractor performance in the areas of enrollment, claims processing, adequate customer service, and responsiveness to physicians.</td>
</tr>
<tr>
<td>D-390.962</td>
<td>National Care Project Physician Input</td>
<td>Rescind. Directive accomplished. The AMA has had discussions with CMS about the importance of physician</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
<td>Recommended Action and Rationale</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D-390.999</td>
<td>Universal Explanation of Medical Benefits Forms</td>
<td>Rescind. Superseded by Policy H-390.865 and AMA re-focus on adoption of the standard transaction for electronic remittance advice (a focus on encouraging an electronic version of a paper explanation of benefits). The AMA has undertaken significant activity to further the goal of adoption of the standard transaction for electronic remittance advice, including the development and publication of an educational toolkit available on the AMA website to help practices implement the standard electronic remittance advice transaction</td>
</tr>
<tr>
<td>D-400.986</td>
<td>The RUC: Recent Activities to Improve the Valuation of Primary Care Services</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-406.994</td>
<td>Safeguard National Provider Identifier and Physician Privacy</td>
<td>Rescind. Directive accomplished. The AMA implemented a complaint form for physicians to register problems stemming from Medicare Administrative Contractor reforms and forwarded this information to CMS. The AMA also asked the states and specialties to forward any concerns they hear from the field so these issues can be tracked. The AMA continues to raise these concerns to CMS.</td>
</tr>
<tr>
<td>D-475.997</td>
<td>Postoperative Care of Surgical Patients</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-70.938</td>
<td>Certified Professional Coders</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-70.940</td>
<td>AMA Program to Readily Retrieve Billing Code Data by Payee within a Practice</td>
<td>Rescind. No longer relevant and superseded by Policy H-190.978.</td>
</tr>
<tr>
<td>H-70.946</td>
<td>Rebundling of Vaccine Codes</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-70.948</td>
<td>Exclusion of Preoperative Services from Surgical Global Fee</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-70.962</td>
<td>Changes in the Bundling of Medical Services by Managed Care Plans</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-70.982</td>
<td>Primary Health Care Reimbursement Coding</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-70.993</td>
<td>Uniform Use of CPT Coding</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
<td>Recommended Action and Rationale</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>H-70.994</td>
<td>Coding of Physician and Non-Physician Services</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-70.995</td>
<td>Collapsing the Codes</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-120.947</td>
<td>Preserving Patients’ Ability to Have Legally Valid Prescriptions Filled</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-130.975</td>
<td>The Emergency Department and the Medical Staff</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-155.963</td>
<td>Health System Expenditures</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-160.951</td>
<td>Access to Primary Care Services</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-165.877</td>
<td>Increasing Coverage for Children</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-185.948</td>
<td>Health Insurance for Children</td>
<td>Rescind. Superseded by Policy H-165.848.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Additionally, Policies H-450.935 and H-410.948 supersede in their</td>
</tr>
<tr>
<td></td>
<td></td>
<td>provision for updating guidelines to reflect evolving evidence.</td>
</tr>
<tr>
<td>H-185.999</td>
<td>Multiple Coverage in Voluntary Health Insurance</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-200.969</td>
<td>Definition of Primary Care</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-205.998</td>
<td>Regionalization of Medical Services</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-210.994</td>
<td>Home Health Care</td>
<td>Retain. Still relevant</td>
</tr>
<tr>
<td>H-220.933</td>
<td>Critical Relevancy of Medical Staff in JCAHO Standards</td>
<td>Rescind, superseded by the adoption of Leadership Standard LD.02.04.01.</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
<td>Recommended Action and Rationale</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>H-220.934</td>
<td>Conflicting Accreditation Standards Among Various Accreditors</td>
<td>Retain, amend as follows: Our AMA will work: (1) with the Joint Commission on Accreditation of Healthcare Organizations, the Centers for Medicare &amp; Medicaid Services, state legislatures and regulating agencies, and other appropriate accrediting organizations, to ensure that there are no conflicts among the standards and their interpretation; (2) to ensure that accreditation remain in the private sector, and not become a function of government.</td>
</tr>
<tr>
<td>H-220.966</td>
<td>Future Directions of the JCAHO</td>
<td>Retain, amend as follows: The AMA urges the JCAHO Joint Commission, in any standards revision process, to make efforts to reduce burdensome and expensive administrative requirements imposed on health care providers that do not directly affect the quality of patient care.</td>
</tr>
</tbody>
</table>
| H-225.956 | Behaviors That Undermine Safety                                               | Retain in part. Section 1 is still relevant, but the directive set forth in section 2 should be rescinded as accomplished. In December 2008, the AMA asked the Joint Commission to delay implementation of Joint Commission Standard LD.03.01.01, in part, because of its broad definition of disruptive behavior. The AMA also adopted its own Model Medical Staff Code of Conduct and continues to encourage organized medical staffs to adopt the AMA model code as part of their medical staff bylaws.  
  1. Our AMA adopted the following policies:  
     A. The Medical Staff…  
     B. The Hospital…  
  2. Our AMA Commissioners to the Joint Commission will urgently convey to The Joint Commission that a one-year moratorium on The Joint Commission Standard LD.03.01.01 is necessary to provide a feasible time frame for the medical staff to bring the medical staff bylaws into compliance with the Standard. |
<p>| H-225.980 | Hospital Medical Staff Section Representation on State Governing Boards       | Retain. Still relevant.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| H-230.994 | Encouragement of Open Hospital Medical Staffs                                | Retain. Still relevant.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| H-235.999 | Physicians Employed by Hospitals Required to be on Staff                     | Retain. Still relevant.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| H-240.975 | Realistic DRG Reimbursement                                                  | Retain. Still relevant.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |</p>
<table>
<thead>
<tr>
<th>Policy #</th>
<th>Policy Title</th>
<th>Recommended Action and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-285.953</td>
<td>Managed Care Organizations - Credentialing</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-330.917</td>
<td>Medicare Reimbursements for Medications</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-330.923</td>
<td>Medicare Toll-Free Number</td>
<td>Rescind. No longer relevant now that toll-free numbers are available and widely publicized by carriers.</td>
</tr>
<tr>
<td>H-330.926</td>
<td>Reform of CMS Technology Assessment Process</td>
<td>Rescind. The Medicare coverage policy envisioned by the policy has been accomplished.</td>
</tr>
<tr>
<td>H-330.936</td>
<td>Physician Ordering of Durable Medical Equipment and Home Health Services</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-335.994</td>
<td>CMS - Standards of Care, Hospital Admissions</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-345.986</td>
<td>Fifty Percent Copayment Requirement for Codes 290-310 Mental Disorders</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
<td>Recommended Action and Rationale</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>H-385.979</td>
<td>Reimbursement for Physicians in a Rehabilitation Setting</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-390.865</td>
<td>Universal Explanation of Benefits Forms</td>
<td>Retain. Still relevant</td>
</tr>
<tr>
<td>H-390.879</td>
<td>Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-390.917</td>
<td>Consultation Follow-Up and Concurrent Care of Referral for Principal Care</td>
<td>Retain in part. In 2010 Medicare ceased paying for CPT consultation codes. Instead, providers may code for a patient evaluation and management (E&amp;M) visit when appropriate. Modify policy to read as follows: (1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation (in the inpatient setting these encounters may be reported using the follow-up consultation codes in CPT and in the outpatient setting these encounters may be reported using the appropriate office or other outpatient setting codes); and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management,</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
<td>Recommended Action and Rationale</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>H-400.945</td>
<td>Insurance Compensation When Medicare Rates Are Decreased</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-400.946</td>
<td>Uncoupling Commercial Fee Schedules from Medicare Conversion Factors</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-400.962</td>
<td>The AMA/Specialty Society RVS Update Process</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-410.969</td>
<td>Payer Use of Practice Parameters</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-465.999</td>
<td>Certification of Rural Hospitals for Medicare</td>
<td>Retain. Still relevant.</td>
</tr>
</tbody>
</table>

and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.
REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-18)
Improving Affordability in the Health Insurance Exchanges
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, “Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization.” The policy states that “our American Medical Association (AMA) will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care.” In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on improving affordability in the individual health insurance marketplace, and Council on Medical Service Report 3, “Ensuring Marketplace Competition and Health Plan Choice.”

The Council believes that there is an opportunity to improve affordability in the health insurance exchanges through extending eligibility for premium tax credits, as well as increasing tax credit amounts for some individuals who are already eligible for them. Extending eligibility for advance premium tax credits to 500 percent of the federal poverty level (FPL) would assist individuals with incomes between 400 and 500 percent FPL to obtain coverage, consistent with Policy H-165.848 on individual responsibility. Another key mechanism to improve health insurance affordability, help balance the individual market risk pool and increase coverage rates among young adults is the provision of “enhanced” tax credits to young adults, which provides those aged 19 to 35 who are eligible for advance premium tax credits with “enhanced” premium tax credits—eg, an additional $50 per month for those ages 19-30, the amount declining to age 35.

The Council recognizes that the effectiveness of premium tax credits as a mechanism to improve health insurance affordability relies on individuals who are eligible for such assistance being aware of their eligibility. Toward that end, the Council recommends adequate funding for and expansion of outreach efforts to increase public awareness of premium tax credits to not only increase the number of people who are insured, but also help to balance the individual market risk pool by increasing overall marketplace enrollment.

The elimination of the federal individual mandate penalty has the potential to cause not only premium increases and coverage losses, but increased market instability starting in 2019. States have the opportunity for innovation to maximize the number of individuals covered and stabilize health insurance premiums. In particular, the Council is encouraged by activities and discussions on the state level pursuing state-level individual mandates, auto-enrollment and/or reinsurance, and believes those mechanisms hold great promise in improving coverage rates and market stability.

The Council is encouraged by the success of the Affordable Care Act’s (ACA) reinsurance program as well as state reinsurance programs under Section 1332 waiver authority in reducing premiums in comparison to what they otherwise would have been. By partially reimbursing plans for the costs of their high-risk enrollees, reinsurance would help stabilize premiums for all individuals with ACA marketplace coverage, while protecting patients with pre-existing conditions. Therefore, the Council recommends the establishment of a permanent federal reinsurance program. Taken together, the Council believes its policy recommendations will provide the AMA with consistent guidance for advocating for our patients.
REPORT OF THE COUNCIL ON MEDICAL SERVICE

Subject: Improving Affordability in the Health Insurance Exchanges

Presented by: Paul A. Wertsch, MD, Chair

Referred to: Reference Committee A
(Jonathan D. Leffert, MD, Chair)

At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, “Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization.” The policy states that “our American Medical Association (AMA) will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care.”

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting. In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on improving affordability in the individual health insurance marketplace, and Council on Medical Service Report 3, “Ensuring Marketplace Competition and Health Plan Choice.”

This report provides background on recent premium increases in the Affordable Care Act (ACA) individual health insurance marketplaces and their associated impact on health plan affordability, outlines potential approaches to improve affordability in the ACA marketplaces, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

Premiums in ACA marketplaces rose significantly in many counties across the country from 2017 to 2018, due to factors including health insurer uncertainty about payment of cost-sharing reductions (CSRs) and enforcement of the individual mandate, lower insurer participation in the marketplaces, as well as more characteristic factors contributing to annual increases, including health care costs and trends. Depending on the county of residence and eligibility for premium tax credits, however, not all individuals have faced increases in their premiums from 2017 to 2018. For example, for a 40 year-old, unsubsidized premiums for the lowest-cost bronze, silver and gold plans increased nationally by an average of 17 percent, 32 percent and 18 percent respectively between 2017 and 2018. Premiums for silver plans experienced larger increases than bronze and gold plans as a result of insurer and state strategies employed in response to the termination of CSR payments.¹ For those consumers who enrolled in coverage via the healthcare.gov platform during the 2017 and 2018 open enrollment periods, the average premium before the application of any tax credit increased from $476 in 2017 to $621 in 2018.²

Even though the federal government has stopped reimbursing insurers for CSRs, insurers are still required under the ACA to offer CSRs to individuals with incomes up to 250 percent of the federal

© 2018 American Medical Association. All rights reserved.
poverty level (FPL) who enroll in silver plans. Insurers, depending on the state in which they offer plans, responded to the termination of CSR payments in one of four main ways in setting premiums for the 2018 plan year:

- Increasing premiums only for silver plans offered inside the marketplace, because CSRs are only available for these plans;
- Increasing premiums for all silver plans, including those offered inside and outside the marketplace;
- Increasing premiums for all ACA-compliant individual market plans, including those offered inside and outside the marketplace; and
- Not adjusting premiums at all in response to the termination of CSR payments, though this strategy was very uncommon.3

Partially as a result of insurer responses to termination of CSR payments, for individuals who are eligible for premium tax credits, subsidized premiums are often lower in 2018 than 2017. Of note, of those consumers who selected or were automatically reenrolled in an ACA marketplace plan during open enrollment this year, 83 percent received a tax credit to lower their premiums.4 The amount of premium tax credits an individual receives is based on the cost of the second lowest cost silver (benchmark) plan available to them. In 2018, for states using the healthcare.gov platform, the average monthly premium for the benchmark plan for a 27-year-old increased by 37 percent ($411) compared to 2017 ($300). Such increases in benchmark plan premiums have yielded much higher tax credit amounts for many individuals. For states using the healthcare.gov platform, the average premium tax credit for individuals with 2017 coverage was estimated to increase by 45 percent from 2017 to 2018, from $382 to $555.5 For consumers who enrolled in plans during the 2018 open enrollment period in states using the healthcare.gov platform and received a tax credit to lower their premiums, the average premium tax credit was $550. Among these consumers with a premium tax credit, the tax credit covered approximately 86 percent of the total premium on average. After the application of the tax credit, the average premium was $89 per month.6 With higher premium tax credit amounts, gold plans became much more affordable, with bronze plans oftentimes having very low or no premiums. In some counties, the premium of the lowest-cost gold plan was even cheaper than the lowest-cost silver plan.

Looking ahead to 2019, resulting from the elimination of the individual mandate penalty due to enactment of tax reform legislation, individuals will become uninsured, and premiums will increase. In fact, the Congressional Budget Office has projected that repealing the individual mandate, starting in 2019, would cause the number of individuals with health insurance coverage to decrease by four million in 2019 and 13 million in 2027. At the same time, average premiums in the nongroup market would increase by approximately 10 percent in most years of the coming decade.7

APPROACHES TO IMPROVE AFFORDABILITY IN THE INDIVIDUAL MARKETPLACE

State-Level Individual Mandates and Auto-Enrollment

In light of the elimination of the federal individual mandate penalty, states have begun contemplating approaches to prevent the projected coverage losses and the level of premium increases anticipated in 2019. While the individual mandate of Massachusetts remains in place, some states are moving forward with individual mandate requirements, with the status and substance of such discussions varying by locality. For example, the New Jersey legislature approved the New Jersey Health Insurance Market Preservation Act, which would institute an individual mandate penalty in the state that largely resembles that of the ACA.8 The Council notes
that state approaches to instituting state-level individual mandates, as well as auto-enrollment, depend on whether a state has an income tax and the extent to which a state operates its own health insurance marketplace.

The auto-enrollment option is also being considered in some states, to be either implemented separately from or in concert with a state-level individual mandate. For example, in Maryland, the Protect Maryland Health Care Act of 2018 has been introduced, which, if enacted into law, would give uninsured residents who would otherwise be charged an individual mandate penalty a choice: pay the penalty, or instead use the penalty amount as a down payment to assist them in purchasing health insurance coverage. If there are plans available that cost no more than any applicable federal premium tax credit amount and the down payment, consumers would be enrolled in such plans. If there are no “zero premium” plans available, the down payment would be placed into an escrow account that accumulates interest, which could then be used to purchase health insurance coverage during the following open enrollment period. If consumers do not select a plan by the end of open enrollment, and a “zero premium” plan has become available to them, they will be auto-enrolled in such coverage. Otherwise, their down payment would be deposited into the newly established Maryland Insurance Stabilization Fund, and be applied toward such initiatives as reinsurance.

State and Federal Reinsurance Programs

The recommendations of Council on Medical Service Report 4-I-17 established Policy H-165.842[3], which prefers reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients. State and federal reinsurance programs have been shown to be effective in yielding premium reductions, in comparison to what they otherwise would have been. On the federal level, the ACA’s temporary reinsurance program helped stabilize premiums in the individual marketplace during the early years of ACA implementation. The program provided payments to plans that enrolled higher-cost individuals whose costs exceeded a certain threshold, also known as an attachment point, up to the reinsurance cap. To fund the ACA’s transitional reinsurance program, insurers and third party administrators paid $63 per enrollee per year in 2014, $44 in 2015 and $27 in 2016. These investments in reinsurance yielded premium reductions. For example, in 2014, the $10 billion reinsurance fund, the result of the $63 per enrollee per year contributions, was estimated to reduce premiums by 10 to 14 percent. The American Academy of Actuaries has stated that a permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums.

States are also using ACA Section 1332 waivers to fund state reinsurance programs. Through an approved 1332 waiver, Alaska was able to implement the Alaska Reinsurance Program (ARP) for 2018 and subsequent years. The ARP covers claims in the individual market for individuals with one or more of 33 identified high-cost conditions to help stabilize premiums. As a result, insurers relinquish both premiums received for such individuals as well as claims they would have paid absent the waiver. Accordingly, premiums are 20 percent lower this year in the average plan on the individual market than they would have been absent the waiver. Other states have moved forward with implementing more traditional state reinsurance programs through Section 1332 waivers. For example, due to an approved 1332 waiver, premiums in Oregon were lower this year in comparison to what they would have otherwise been.

In the 115th Congress, federal legislation has been introduced to provide funding for reinsurance programs. In the Senate, Senators Susan Collins (R-ME) and Bill Nelson (D-FL) introduced S 1835, the Lower Premiums Through Reinsurance Act of 2017, which would allow states to leverage Section 1332 waivers to apply and receive funding for reinsurance or invisible high-risk
pool programs. The legislation would provide $5 billion in total for funding, split evenly between fiscal years 2018 and 2019.15

In the House of Representatives, Congressmen Ryan Costello (R-PA) and Collin Peterson (D-MN) introduced HR 4666, the Premium Relief Act of 2017, which would establish the Patient and State Stability Fund, which would provide up to $30 billion from 2019 to 2021 for the Secretary of Health and Human Services (HHS) to allocate at his discretion to be used for defined, outlined purposes, including reinsurance. If states do not apply for funding and administer their own programs under the bill, a federal reinsurance program would be established in said states by default. The legislation would also provide for reimbursements to insurers for CSR payments retroactively for the last quarter of 2017, as well as for 2019 and 2020.16

HR 3311/S 1354, the Individual Health Insurance Marketplace Improvement Act, has been introduced by Senator Thomas Carper (D-DE) and Congressman James Langevin (D-RI). If enacted into law, the legislation would create a permanent federal reinsurance program. The reinsurance program would provide payments to health plans to cover 80 percent of insurance claims incurred by plan enrollees between $50,000 and $500,000 from 2018-2020, and between $100,000 and $500,000 in 2021 and beyond.17,18

There was also debate to include funding for reinsurance as part of HR 1625, the Consolidated Appropriations Act of 2018. However, ultimately such funding for reinsurance was not included in the final package.

Expansion of Eligibility for Premium Tax Credits

Under the ACA, eligible individuals and families with incomes between 100 and 400 percent FPL (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges. The size of premium credits is based on household income relative to the cost of premiums for the benchmark plan, which is the second-lowest-cost silver plan offered on the exchange. The premium credit thereby caps the percentage of income that individuals pay for their premiums.

Individuals and families with incomes over 400 percent FPL are left without any premium assistance. The Council notes that the policy of our AMA in support of an individual responsibility requirement (Policy H-165.848) states that once a system of refundable, advanceable tax credits inversely related to income is implemented, that individuals and families earning less than 500 percent FPL should be required to obtain coverage. Extending advanceable premium tax credits to those with incomes above 400 percent FPL would not only cause some individuals with incomes between 400 and 500 percent FPL to be able to afford and obtain health insurance coverage, but would also be highly consistent with Policy H-165.848.

Enhanced Premium Tax Credits for Young Adults

In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with “enhanced” premium tax credits—eg, an additional $50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio. Smaller amounts could be provided to individuals between ages 30–35. Under this policy option, the total credit, including the “enhanced” tax credit, could not exceed the cost of the second-lowest-cost silver plan available to them. Modeling of “enhanced” premium tax credits projects that individual market enrollment...
would increase by one million with the proposal in place. Of note, this approach to expanding coverage among young adults would cost less to the federal government than changing the age rating ratio from 3:1 to 5:1, as the latter would cause premiums for older adults to increase, as well as the associated premium tax credit amounts. Significantly, changing the age rating would cause some older adults to become uninsured; whereas with “enhanced” premium tax credits, individual market enrollment among older adults would remain largely unchanged.

Improved Outreach About Premium Subsidies

In August 2017, the Centers for Medicare & Medicaid Services announced that it would be spending $10 million on educational activities targeted at new and returning marketplace enrollees for the open enrollment period for the 2018 plan year, which represented a 90 percent cut from the $100 million spent on ACA-related advertising in 2017. In addition, federal spending on the ACA’s navigator program, which provides outreach, education and enrollment assistance to consumers eligible for marketplace coverage as well as Medicaid, was cut 40 percent. However, states operating their own health insurance marketplaces and navigator programs continued to dedicate financial resources to outreach and educational activities, as did some non-profit entities. It has been suggested that the difference in resources dedicated to outreach and education between states operating their own marketplaces and states that relied on healthcare.gov impacted enrollment successes in the marketplaces for 2018. For example, in the 16 states and DC with state-based marketplaces, 2018 plan signups during the open enrollment period stayed consistent with that of 2017, with a very slight increase. On the other hand, in the 34 states that fully relied on the federal healthcare.gov platform, total plan signups decreased by more than five percent in comparison to 2017.

At the same time, of the 27.5 million nonelderly people who were uninsured in 2016, 7.9 million were eligible for premium tax credits to purchase coverage through the marketplace. Data suggest that there remains a lack of awareness about premium tax credits and other financial assistance that may be available, as well as confusion about eligibility rules. The Council notes that for individuals who are eligible for premium tax credits but remain uninsured, improved outreach and education about premium subsidies and their coverage options in the marketplace will be critical to increase the number of people who are insured, and may help to balance the individual market risk pool by increasing marketplace enrollment.

RELEVANT AMA POLICY

Over the course of the past couple of years, the Council has developed and presented reports specifically addressing improving health insurance affordability. CMS Report 4-I-17 focused on essential health benefits and the relative merits of high-risk pools versus reinsurance. The resulting policies, H-165.846[3] and H-165.842[3], oppose the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; oppose waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and prefer reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients. CMS Report 8-I-15 established Policy H-165.828, which supports legislation or regulation to fix the “family glitch;” supports allowing workers and their families to be eligible for subsidized exchange coverage if their employer coverage has premiums high enough to make them exempt from the individual mandate; encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and
supports capping the tax exclusion for employment-based health insurance as a funding stream to
improve health insurance affordability, including for individuals impacted by the inconsistency in
affordability definitions, individuals impacted by the “family glitch,” and individuals who forego
cost-sharing subsidies despite being eligible.

Policy H-165.841 supports the overall goal of ensuring that every American has access to
affordable high quality health care coverage. Policy H-165.845 states that health insurance
coverage should be equitable, affordable, and sustainable. Policy H-165.838 supports insurance
market reforms that expand choice of affordable coverage. Policy H-165.920 supports individual
tax credits as the preferred method for people to obtain health insurance coverage. Policy
H-165.865 states that tax credits should be refundable; inversely related to income; large enough to
ensure that health insurance is affordable for most people; fixed-dollar amounts for a given income
and family structure; and advanceable for low-income persons who could not afford the monthly
out-of-pocket premium costs. Policy H-373.998 states that health reform plans should effectively
provide universal access to an affordable and adequate spectrum of health care services, maintain
the quality of such services, and preserve patients’ freedom to select physicians and/or health plans
of their choice.

Policy H-165.848 supports a requirement that individuals and families who can afford health
insurance be required to obtain it, using the tax structure to achieve compliance. The policy
advocates a requirement that those earning greater than 500 percent FPL obtain a minimum level of
catastrophic and preventive coverage. Only upon implementation of tax credits or other coverage
subsidies would those earning less than 500 percent FPL be subject to the coverage requirement.
Policy H-165.856 supports health insurance coverage of pre-existing conditions with guaranteed
issue within the context of an individual mandate, in addition to guaranteed renewability. In CMS
thoughtful consideration to alternatives to requiring individual responsibility, including the
imposition of penalties for late enrollment, similar to Medicare Part D. The Council found that
analyses fail to prove that such alternatives would be as effective in covering the uninsured and
promoting a balanced risk pool of individuals between those who are sick and those who are
healthy as an individual responsibility requirement.

Addressing state innovation, Policy D-165.942 advocates that state governments be given the
freedom to develop and test different models for covering the uninsured, provided that their
proposed alternatives: a) meet or exceed the projected percentage of individuals covered under an
individual responsibility requirement while maintaining or improving upon established levels of
quality of care; b) ensure and maximize patient choice of physician and private health plan; and
c) include reforms that eliminate denials for pre-existing conditions.

DISCUSSION

With almost 12 million Americans enrolled in coverage offered through health insurance
exchanges this year, the Council affirms that progress has been made on a long-standing policy
priority of the AMA—supporting the purchase of individually selected and owned health insurance
coverage with use of refundable and advanceable tax credits inversely related to income. However,
the Council remains concerned with the premium increases experienced in the health insurance
marketplaces from their launch in the 2014 plan year, and at the same time recognizes that such
increases primarily impact those who are not eligible for premium tax credits. The Council believes
that there is an opportunity to extend eligibility for advance premium tax credits which are
inversely related to income consistent with Policy H-165.865 to 500 percent of FPL, which would
assist individuals with incomes between 400 and 500 percent FPL to obtain coverage, consistent
with Policy H-165.848 on individual responsibility.

The Council recognizes that the effectiveness of premium tax credits as a mechanism to improve
health insurance affordability relies on individuals who are eligible for such assistance being aware
of it. It is noteworthy that of the 27.5 million nonelderly people who were uninsured in 2016,
7.9 million were eligible for premium tax credits to purchase coverage through the marketplace.
There is a clear opportunity to improve awareness about premium tax credits and other financial
assistance that may be available to enrollees, as well as clear up confusion about eligibility rules.
Accordingly, the Council recommends adequate funding for and expansion of outreach efforts to
increase public awareness of premium tax credits to not only increase the number of people who
are insured, but also help to balance the individual market risk pool by increasing overall
marketplace enrollment.

Another key mechanism to help balance the individual market risk pool and increase coverage rates
is the provision of “enhanced” tax credits to young adults. This proposal, which provides those
aged 19 to 35 who are eligible for advance premium tax credits with “enhanced” premium tax
credits—eg, an additional $50 per month for those ages 19-30, the amount declining to age 35—
has been projected to spur increases in young adult enrollment in the marketplace. Importantly, this
policy recommendation maintains the current premium tax credit structure which is inversely
related to income and as such is highly consistent with AMA policy. The Council notes that, as
outlined in long-standing Policy H-165.920 and Policy H-165.828, eliminating or capping the
employee tax exclusion for employment-based insurance could be used as a funding stream for the
mechanisms proposed to improve health insurance affordability in this report.

The elimination of the federal individual mandate penalty has the potential to cause not only
premium increases and coverage losses, but increased market instability starting in 2019. An
opportunity exists for state innovation to maximize the number of individuals covered and stabilize
health insurance premiums. In particular, the Council is encouraged by activities and discussions
on the state level pursuing state-level individual mandates, auto-enrollment and/or reinsurance, and
believes those mechanisms hold great promise moving forward.

Finally, the Council is encouraged by the success of the ACA’s reinsurance program as well as
state reinsurance programs under Section 1332 waiver authority in reducing premiums in
comparison to what they otherwise would have been. By partially reimbursing plans for the costs
of their high-risk enrollees, reinsurance would help stabilize premiums for all individuals with
ACA marketplace coverage, while protecting patients with pre-existing conditions. Therefore, the
Council is recommending the establishment of a permanent federal reinsurance program. Upon the
program’s launch, it will be essential to monitor and evaluate the program’s impact on premiums.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder
of the report be filed:

1. That our American Medical Association (AMA) support adequate funding for and
   expansion of outreach efforts to increase public awareness of advance premium tax credits.
   (New HOD Policy)

2. That our AMA support expanding eligibility for premium tax credits up to 500 percent of
   the federal poverty level. (New HOD Policy)
3. That our AMA support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income. (New HOD Policy)

4. That our AMA encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. (New HOD Policy)

5. That our AMA support the establishment of a permanent federal reinsurance program. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES


4 Centers for Medicare & Medicaid Services, supra note 2.


6 Centers for Medicare & Medicaid Services, supra note 2.


15 S 1835, the Lower Premiums Through Reinsurance Act of 2017. Available at: https://www.congress.gov/bill/115th-congress/senate-bill/1835/text?q=%7B%22search%22%3A%5B%22reinsurance%22%5D%7D&r=1.


18 S 1354, the Individual Health Insurance Marketplace Improvement Act. Available at: https://www.congress.gov/bill/115th-congress/senate-bill/1354/text?q=%7B%22search%22%3A%5B%22reinsurance%22%5D%7D&r=5.


20 Eiber and Liu, supra note 19.


REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-18)
Ensuring Marketplace Competition and Health Plan Choice
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, “Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization.” The policy states that “our American Medical Association (AMA) will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care.” In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on ensuring marketplace competition and health plan choice and specifically reviews approaches to a public option, and Council on Medical Service Report 2, “Improving Affordability in the Health Insurance Exchanges.”

The Council is concerned with the potential for some state and federal activities to lead to market segmentation, with healthier individuals enrolling in skimpier plans, and with individuals who for health and other reasons enroll in plans following Affordable Care Act (ACA) requirements. As a result of such adverse selection, there will likely be increased costs for individuals in plans following ACA requirements, resulting from sicker risk pools. To strengthen and ensure the sustainability of the individual health insurance marketplace, the Council supports health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits. In the same light, the Council believes that the AMA should not support coverage options that are exempted from such mandated benefits. As such, the Council is recommending the reaffirmation of Policy D-180.986 concerning “sham” health insurers.

The Council agrees with the sentiment of many physicians that insufficient competition in the ACA marketplaces remains an issue to be addressed. However, the Council is concerned that public option proposals that rely on Medicaid and/or Medicare payment rates and/or tie physician participation in Medicare and/or Medicaid to a public option could negatively impact physician practices and physician practice sustainability, as well as patient access to care and choice of health plan. As such, the Council recommends the reaffirmation of Policy H-165.838, which states that health insurance coverage options offered in a health insurance exchange should be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.

To ensure patients are not left without coverage options in the marketplaces, consistent with the recommendation of a wide array of policy experts across the political spectrum, the Council recommends that our AMA support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. This strategy, unlike some others advocating for a public option, enables patient choice of private health plans, ensures physician freedom of practice, does not require physician participation, and recognizes the value of payment rates being established through meaningful negotiations and contracts.
At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, “Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization.” The policy states that “our American Medical Association (AMA) will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care.”

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting. In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on ensuring marketplace competition and health plan choice and specifically reviews approaches to a public option, and Council on Medical Service Report 2, “Improving Affordability in the Health Insurance Exchanges.”

This report provides background on health plan choice and competition in the Affordable Care Act (ACA) marketplaces, highlights regulatory and legislative activity that could have marketplace impacts, outlines various approaches to ensuring marketplace coverage options, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

This year, there is an average of 3.5 insurers participating in each state’s ACA health insurance marketplace, ranging from one insurer in Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming, to 12 insurers in New York. Approximately 26 percent of marketplace enrollees, living in 52 percent of counties, have only one insurer on the marketplace from which to select plans. Conversely, roughly half of enrollees, living in 18 percent of counties, have a choice of three or more insurers. Within states, there are differences between rural and urban areas as to insurer participation in the marketplace. For 2018, counties in metropolitan areas have on average two insurers participating in the marketplace, whereas non-metro counties have 1.6 insurers participating on average. In 2017, 87 percent of marketplace enrollees lived in counties in metropolitan areas.

Plans that are sold in the ACA marketplaces are required to be certified as qualified health plans (QHPs). As a condition of QHP certification, QHP insurers must provide at least one silver (covers 70 percent of benefit costs) and one gold level plan (covers 80 percent of benefit costs). Therefore, at a minimum, consumers in counties with one insurer are expected to have at least two plans from which to choose. Data show, however, that there is wide variation in the number of unique plans...
offered, even in counties with one or two insurers participating in the marketplace. In 2017, in states using the healthcare.gov platform, counties with a single insurer participating had between two and 28 unique plan offerings with the average nearing 11. In counties with two insurers participating, there were between four and 61 unique plans to choose from, with 16 plans being the approximate average.3,4

REGULATORY ACTIVITY IMPACTING MARKETPLACES

Association Health Plan Proposed Rule

Proposed federal regulations have been released this year, which, if finalized, could impact the competition in and stability of ACA marketplaces. In January, the Department of Labor (DOL) released a proposed rule regarding Association Health Plans (AHPs) in response to Presidential Executive Order 13813 (Promoting Healthcare Choice and Competition Across the United States).5 The proposed rule interprets the term “employer” to include self-employed and sole-proprietors for purposes of becoming an employer member of an AHP, which is important to the risk pool of the ACA marketplaces.

Under the proposed rule, AHPs with 51 or more “employees” can offer health insurance that qualifies as large group coverage to all of its employer members. Large group coverage does not have to comply with many of the ACA’s consumer protections. These protections include providing 10 essential health benefit (EHB) categories – including maternity care, prescription drugs, and mental health and substance use disorder services – that the ACA requires of insurance sold to individuals and small businesses; prohibiting varying rates based on gender, age, occupation, and group size; having a single risk pool for all enrollees to set premium rates; and risk adjustments of claims. Importantly, key cost protections guaranteed in the ACA, such as the annual cap on out-of-pocket costs and the ban on annual and lifetime limits, are only applicable to services considered EHBs.

Concerns have been raised that by enabling self-employed individuals and sole-proprietors to have access to AHP group coverage, the proposed rule has the potential to lead to healthy self-employed individuals enrolling in AHP coverage rather than ACA marketplace coverage. As a result of such adverse selection, individuals in plans following ACA requirements are expected to face higher premiums, resulting from sicker risk pools.6,7,8 At the same time, the Council notes, self-employed individuals enrolling in AHP coverage could be without guaranteed coverage of EHBs and their associated protections against annual and lifetime limits, and out-of-pocket expenses. Such coverage could be potentially problematic for individuals with pre-existing conditions, or enrollees who become sick over the course of the plan year.

Short-Term Limited Duration Plan Proposed Rule

In February, also in response to Presidential Executive Order 13813, the Departments of Health and Human Services (HHS), Labor, and Treasury issued a proposed rule addressing the regulation of short-term, limited duration insurance (STLDI) coverage. Unlike ACA marketplace plans, STLDI plans do not have to comply with the market reforms and consumer protections of the ACA. As such, STLDI plans can deny coverage or charge higher premiums based on health status; exclude coverage for pre-existing conditions; impose annual or lifetime limits; have higher out-of-pocket limits than the ACA maximums; not cover EHB categories; rescind coverage; and not comply with medical loss ratio requirements. Currently, STLDI coverage can only be offered for three months at a time, and if individuals enroll in STLDI plans for more than three months, they may have to pay the individual mandate penalty. By limiting STLDI coverage to three months, the
purpose of STLDI plans was to serve as a bridge between coverage in plans offering meaningful coverage. Under the proposed rule, however, STLDI coverage could again be offered for periods up to 364 days, with the potential for consumers to reapply for coverage at the end of the 364-day period.

In the proposed rule, the agencies outlined the following potential benefits and costs:

- Increased access to affordable health insurance for consumers unable or unwilling to purchase Patient Protection and Affordable Care Act (PPACA)-compliant plans, potentially resulting in improved health outcomes for them;
- Increased choice at lower cost and increased protection (for consumers who are currently uninsured) from catastrophic health care expenses for consumers purchasing short-term, limited-duration insurance;
- Potentially broader access to health care providers compared to PPACA-compliant plans for some consumers;
- Reduced access to some services and providers for some consumers who switch from PPACA-compliant plans;
- Increased out-of-pocket costs for some consumers, possibly leading to financial hardship; and,
- Worsening of States’ individual market single risk pools and potential reduced choice for some other individuals remaining in those risk pools.”

State-Level Activities: Idaho and Iowa

In January, Idaho Governor Butch Otter issued Executive Order No. 2018-02, “Restoring Choice in Health Insurance for Idahoans,” which directed “the Idaho Department of Insurance to approve options that follow all State-based requirements, even if not all PPACA requirements are met, so long as the carrier offering the option also offers an exchange-certified alternative in Idaho.” As a result, the Idaho Insurance Department director issued an insurance bulletin recognizing and outlining the requirements of such plans. As outlined in the bulletin, state-based plans could have pre-existing condition exclusions for individuals without continuous qualifying coverage within 63 days of the plan’s effective date. In addition, such plans would not be required to cover all EHB categories required under the ACA, have the ability to impose annual limits of $1 million, and not be required to abide by the out-of-pocket maximums outlined in the ACA. While enrollees in state-based and ACA-compliant plans would be considered to be in the same risk pool, premiums for state-based plans could vary based on age (5:1 instead of 3:1 ratio), tobacco use and health status.

In response, the Centers for Medicare & Medicaid Services (CMS) issued a letter to Idaho regarding its bulletin, stating that that the agency has reason to believe that Idaho would be failing to substantially enforce the provisions of the ACA. If Idaho fails to enforce the ACA, CMS stated that it has the authority to enforce the provisions of the law on behalf of the state. At the same time, CMS also stated that Idaho could potentially modify its proposal to offer state-based plans under the exception for STLDI coverage.

In Iowa, legislation has been signed into law that will allow the Iowa Farm Bureau Federation to offer health insurance plans that would not, under law, be considered to be insurance. As such, the plans would not have to comply with ACA benefit standards and consumer protections, including prohibitions on pre-existing condition exclusions and denials, essential health benefits and age rating. In addition, they would not be subject to customary state regulations pertaining to health insurance, including those pertaining to rate review and solvency. The Council notes that the state of Tennessee has a similar law in place.
VARIOUS APPROACHES TO ENSURE MARKETPLACE COVERAGE OPTIONS

Concerns about insufficient competition on the marketplaces and affordability have led thought leaders, as well as federal and state legislators and gubernatorial candidates, to put forward proposals to ensure marketplace coverage options, including the creation of a public option. Approaches to a public option vary in many respects. For example, while some proposals would require provider participation in a public option, others would allow providers to choose whether or not they want to participate in the plan offerings put forth in the event of bare counties. There are also different approaches to provider payment: through negotiation, or being tied to Medicare or Medicaid payment levels. In addition, while some public option proposals would build upon the Medicaid or Medicare programs, other proposals would use private health plans to ensure marketplace competition.

Federal and State Legislative Approaches

In the 115th Congress, federal legislation has been introduced addressing a public option. Congressman Peter DeFazio (D-OR) has introduced HR 1307, the Public Option Deficit Reduction Act, which would require the Secretary of HHS to offer a public option on the marketplaces. The public option envisioned in HR 1307 would comply with requirements for plans offered through marketplaces, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing. In addition, it would offer bronze, silver and gold plans, with the option to also offer platinum plans. Premiums would be geographically adjusted, and set at a level sufficient to fully finance the costs of the health benefits provided, administrative costs, and a contingency margin. Provider payment rates would be at Medicare rates, with the Secretary of HHS modifying payment rates in order to accommodate payment for services not otherwise covered in Medicare, including well-child visits. For the first three years, payment rates would be five percent higher than Medicare in order to incentivize provider participation. Medicare participating providers would also be considered to be providers in the public option unless they opt out. The bill appropriates funding for the establishment of the public health insurance option, which HHS must repay over 10 years.

Senator Brian Schatz (D-HI) and Congressman Ben Ray Luján (D-NM) introduced S 2001/HR 4129, the State Public Option Act. If enacted into law, the legislation would give states the option to establish a Medicaid buy-in plan for residents regardless of income. Interestingly, for individuals ineligible for premium tax credits, their premiums cannot exceed 9.5 percent of household income. If these individuals were to enroll in other plans on state ACA marketplaces, their premiums would not be capped as a percentage of their income. In terms of physician payment rates, the State Public Option Act would make permanent a payment increase to Medicare levels for a range of primary care providers. These bills are similar to Assembly Bill 374 that passed the Nevada legislature, but was vetoed by the governor in June 2017. Other states have also considered a Medicaid buy-in approach, including Massachusetts and Minnesota.

Senator Debbie Stabenow (D-MI) has introduced S 1742, the Medicare at 55 Act, which would provide an option for individuals age 55 to 64 to buy into Medicare or Medicare Advantage. Similarly, Congressman Brian Higgins (D-NY) introduced HR 3748, the Medicare Buy-In and Health Care Stabilization Act of 2017, which would allow individuals age 50 and 64 to buy into Medicare. Under both bills, premiums would be based on estimating the average, annual per capita amount for benefits and administrative expenses that would be payable under Parts A, B, and D (including, as applicable, under Part C) for the buy-in populations. Notably, individuals would be able to apply premium tax credits and cost-sharing reductions toward the purchase of such coverage. These proposals are alternatives to more comprehensive proposals that would allow all
individuals to buy into Medicare, or provide Medicare for all (eg, S. 1804, the Medicare for All Act of 2017, introduced by Senator Bernie Sanders [I-VT]).

Congresswoman Dita Titus (D-NV) introduced HR 4394, the Bare County Buy-in Act of 2017, which would require the Secretary of HHS to make available a public option for health insurance coverage for individuals residing in an area without any marketplace plan options. The public option would consist of a silver-level plan that provides coverage for essential health benefits. Providers who participate in Medicare or Medicaid would be considered to be participating providers in the public option unless they opt out. While the legislation states that the Secretary of HHS should establish provider payment rates through negotiated agreements, the bill also stipulates that if the Secretary and health care providers are unable to reach a negotiated agreement, that Medicare fee-for-service (FFS) payment rates should be used.

Leveraging FEHBP to Ensure Marketplace Plan Choice

The Federal Employees Health Benefits Program (FEHBP) provided health insurance coverage to approximately 8.2 million federal employees, retirees, and their dependents in 2016. By entering into contracts with qualified health insurance carriers, the US Office of Personnel Management (OPM) offers through FEHBP two primary types of plans – FFS plans (most of which have a preferred provider organization component) and health management organization (HMO) plans. While FFS plans are offered nationwide to all enrollees, HMO plans offer coverage in certain geographic areas. In reviewing health plans to be offered under FEHBP, OPM considers the ability of plans to provide reasonable access to and choice of primary and specialty medical care throughout the service area.

In 2015, the median number of FEHBP plan offerings in a county was 24, most of which were nationwide FFS plans available in all counties. However, despite this level of choice of health plan, FEHBP enrollment is highly concentrated. The median county market share held by the largest FEHBP carrier was 72 percent in 2015, with the market share of the largest three carriers being 90 percent. Blue Cross Blue Shield Association (BCBSA), which offers two nationwide FFS plans, was the largest FEHBP carrier in 98 percent of counties in 2015. BCBSA’s two nationwide FFS plans vary based on factors including premiums and provider network breadth. The Government Employees Health Association, Inc., which also offers nationwide FFS plans, held the second or third largest market share in 77 percent of counties in 2015. Kaiser Permanente, which offers HMO plans, was the third largest FEHBP carrier in 2015.

Leveraging health plan FEHBP participation has been included in a leading proposed solution to prevent bare counties in the marketplaces. Tim Jost, a health law expert who is Emeritus Professor at the Washington and Lee University School of Law and contributor to the Health Affairs Blog, proposed that, in the short term, “the largest two FEHBP insurers in any county should be required as a condition of continued participation in the program to offer at least one silver-level plan though the federal exchange in all counties that would otherwise be without coverage. These plans should be eligible for premium tax credits and could otherwise charge actuarially appropriate premiums.” Jost’s proposal was cited in a bipartisan agreement to fix the ACA released in 2017, notably supported by Joseph Antos (American Enterprise Institute); Stuart Butler (The Brookings Institution); Lanhee Chen (Hoover Institution, Stanford University, Romney-Ryan 2012); John McDonough (Harvard University, Senator Ted Kennedy); Ron Pollack (Families USA); Sara Rosenbaum (George Washington University, former MACPAC chair); Grace-Marie Turner (Galen Institute); Vikki Wachino (Former Director, Center for Medicaid and CHIP Services); and Gail Wilensky (former HCFA Administrator and Deputy Assistant to President G HW Bush).
RELEVANT AMA POLICY

Policy H-165.838 supports health system reform initiatives that are consistent with long-standing AMA policies on pluralism, freedom of choice, freedom of practice, and universal access for patients. The policy also states that insurance coverage options offered in a health insurance exchange should be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians. Policy H-165.839 states that health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage.

Regarding meaningful coverage, Policy H-165.846 states that existing federal guidelines regarding types of health insurance coverage (eg, Title 26 of the US Tax Code and FEHBP regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. The policy also advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any EHB package for children; opposes the removal of categories from the EHB package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. Policy H-165.865 states that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the US Code.

Addressing AHPs, Policy D-165.971 supports any AHPs that safeguard state and federal patient protection laws, including those state regulations regarding fiscal soundness and prompt payment. Similarly, Policy H-180.946 supports the selling of insurance across state lines that ensure that patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. Relevant to both AHPs and STLDI plans, while Policy H-165.856 supports the removal of barriers to the formation and operation of group purchasing alliances, the policy also calls for greater national uniformity of market regulation regardless of type of sub-market, geographic location, or type of health plan, and raises concerns with adverse selection.

Policy D-180.986 states that our AMA will encourage local, state, and federal regulatory authorities to aggressively pursue action against “sham” health insurers. By contrast, Policy H-165.882 supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws.

Regarding a Medicare buy-in, Policy H-330.896 supports restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits. Concerning Medicaid, Policy D-290.979 states that theAMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent of the federal poverty level (FPL), or 138 percent FPL including the income disregard, as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver health care services more effectively, even as coverage is expanded.
DISCUSSION

In light of long-standing AMA policy (Policy H-165.856) advocating for greater national uniformity of market regulation across health insurance markets, and recognizing that departures from such uniform regulation should not create adverse selection, the Council believes it is essential that health plans competing to enroll individuals operate on a level playing field with the same rules applying to all plans. The Council is concerned with the potential for certain state and federal activities to lead to market segmentation, with healthier individuals enrolling in skimpier plans, and with individuals who for health and other reasons enrolling in plans following ACA requirements. As a result of such adverse selection the risk pools will likely be less healthy and there will likely be increased costs for individuals in plans following ACA requirements.

The AMA has long supported efforts to maximize health plan choices for individuals seeking coverage. However, it is imperative that state and federal consumer protection laws be maintained, AMA’s key principles on health system reform be upheld, and patients have meaningful health insurance coverage options. AMA policy opposes denials and exclusions due to pre-existing conditions, and recognizes the protection that EHB coverage provides against out-of-pocket expenses, and annual and lifetime limits.

To strengthen and ensure the sustainability of the individual health insurance marketplace, upon which AMA’s proposal for reform relies, the Council supports health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and EHBs. In the same light, the Council believes that the AMA should not support coverage options that are exempted from such mandated benefits, due to their negative impact on marketplace stability, risk pools and plan affordability, resulting from adverse selection. As such, the Council recommends the reaffirmation of Policy D-180.986, which states that our AMA will encourage local, state, and federal regulatory authorities to aggressively pursue action against “sham” health insurers, and the rescission of Policy H-165.882, as it has been superseded by Policy D-180.986 and other AMA policies, and predates the ACA. The Council also recommends rescinding Policy D-165.934, which calls for the study that has been accomplished by the development of this report.

The Council agrees with the sentiment of many physicians that insufficient competition in the ACA marketplaces remains an issue to be addressed. However, the Council is concerned that public option proposals that rely on Medicaid and/or Medicare payment rates and/or tie physician participation in Medicare and/or Medicaid to a public option could negatively impact physician practices and physician practice sustainability, as well as patient access to care and choice of health plan. As such, the Council recommends the reaffirmation of Policy H-165.838, which states that health insurance coverage options offered in a health insurance exchange should be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.

To ensure patients are not left without coverage options in the marketplaces, consistent with the recommendation of a wide array of policy experts across the political spectrum, the Council recommends that our AMA support requiring the largest two FEHBP insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. The Council notes that this proposal would not allow individuals to buy-in to FEHBP plans. Rather, individuals in otherwise bare counties would have the choice of at least two silver plans that abide by ACA requirements, offered by the two largest FEHBP insurers in their county. Importantly, this proposal, unlike some others advocating for a public option, enables patient
choice of private health plans, ensures physician freedom of practice, does not require physician
participation, and recognizes the value of payment rates being established through meaningful
negotiations and contracts.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder
of the report be filed:

1. That our American Medical Association (AMA) support health plans offering coverage
   options for individuals and small groups competing on a level playing field, including
   providing coverage for pre-existing conditions and essential health benefits. (New HOD
   Policy)

2. That our AMA oppose the sale of health insurance plans in the individual and small group
   markets that do not comply with Affordable Care Act requirements, including those related
   to pre-existing condition protections and essential health benefits, except in the limited
   circumstance of short-term limited duration insurance offered for no more than three
   months. (New HOD Policy)

3. That our AMA reaffirm Policy H-165.838, which states that health insurance coverage
   options offered in a health insurance exchange should be self-supporting; have uniform
   solvency requirements; not receive special advantages from government subsidies; include
   payment rates established through meaningful negotiations and contracts; not require
   provider participation; and not restrict enrollees’ access to out-of-network physicians.  
   (Reaffirm HOD Policy)

4. That our AMA support requiring the largest two Federal Employees Health Benefits
   Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one
   silver-level marketplace plan as a condition of FEHBP participation. (New HOD Policy)

5. That our AMA reaffirm Policy D-180.986, which states that our AMA will encourage
   local, state, and federal regulatory authorities to aggressively pursue action against “sham”
   health insurers. (Reaffirm HOD Policy)

6. That AMA Policy H-165.882 be rescinded. (Rescind HOD Policy)

7. That AMA Policy D-165.934 be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


2. 45 CFR 156.200 - QHP issuer participation standards.


11. HR 1307, the Public Option Deficit Reduction Act. Available at: https://www.congress.gov/115/bills/hr1307/BILLS-115hr1307ih.pdf.


22 HR 4394, the Bare County Buy-in Act of 2017. Available at: https://www.congress.gov/115/bills/hr4394/BILLS-115hr4394ih.pdf.


REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-18)
Insulin Affordability
(Resolution 826-I-17)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2017 Interim Meeting, the House of Delegates referred Resolution 826, “Improving Affordability of Insulin,” which was sponsored by the American Association of Clinical Endocrinologists and the Endocrine Society, and which directed the American Medical Association (AMA) to: (1) work with relevant medical specialty societies to convene a summit with participation by patients, clinicians, manufacturers, pharmacy benefit managers (PBMs), insurers and the appropriate federal representatives to highlight the dramatic increase in insulin costs and identify potential solutions; (2) pursue solutions to reduce patient cost sharing for insulin and ensure patients benefit from rebates at the point of sale; (3) work with health insurance companies and federal agencies to stabilize drug formularies and reduce non-medical switching by encouraging plans to cover insulin products at the same cost listed on a drug formulary throughout the entire plan year; (4) encourage insulin price and cost transparency among pharmaceutical companies, PBMs and health insurance companies; and (5) work with electronic medical record vendors and insurance companies to integrate current formularies and price information into all systems so physicians and patients can make informed decisions on insulin products to reduce cost burdens on patients. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting.

Approximately six million Americans use insulin, a drug that has experienced dramatic price increases over the past decade. High insulin prices impact stakeholders throughout the health care system, from patients to health plans/payers and PBMs. The Council notes that insulin is one of the many essential drugs across all categories of pharmaceuticals to recently experience remarkable price increases.

A variety of complicated factors contribute to increases in insulin prices, and this report examines opportunities to identify more affordable alternatives to high-priced insulin. The Council recommends supporting physician education initiatives focused on drug price and cost transparency and the cost-effectiveness of insulin therapies. Additionally, the Council recommends that our AMA disseminate relevant model state legislation and provide assistance, upon request, to state medical associations in support of legislative and regulatory efforts to improve drug price and cost transparency. Finally, the Council recommends that our AMA encourage the Federal Trade Commission and Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate.

In addition, the report describes extensive AMA policy and highly visible AMA advocacy that directly respond to the resolves of referred Resolution 826-I-17. Accordingly, the Council recommends reaffirmation of policies which support: monitoring the relationships between PBMs and the pharmaceutical industry; authorizing federal action to address price gouging and increase patient access to affordable drugs; prescription drug price and formulary transparency; value based insurance design and cost-sharing requirements that consider factors known to affect patient compliance; access to information about the out-of-pocket cost of prescription drugs; and continued collaboration with the Food and Drug Administration on controversial issues including drugs, biologics, and pharmaceuticals.
At the 2017 Interim Meeting, the House of Delegates referred Resolution 826, “Improving Affordability of Insulin,” which was sponsored by the American Association of Clinical Endocrinologists (AACE) and the Endocrine Society (ES), and which directed the American Medical Association (AMA) to:

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

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting. This report highlights insulin as one among the many prescription drugs to recently experience exceptional price increases, government and legal actions to address insulin affordability, opportunities to identify more affordable options for patients in need, and the strong ongoing efforts of the AMA to address affordability of pharmaceuticals. Finally, this report presents policy recommendations.

BACKGROUND

Approximately 30 million Americans have diabetes, and approximately six million Americans use insulin. As explained by the AACE and the ES, patients with type 1 diabetes need insulin for survival and frequently insulin is the only drug that can control the diabetes of patients with type 2 diabetes. Insulin can be very expensive, and the price has increased dramatically over the course of the past decade. For example, the annual retail price of Humulin R (U-500) 500 units/mL—an insulin marketed by Eli Lilly and Company (Lilly)—increased from $2,487 at the end of 2005 to $15,860 by the end of 2015. Humulin is one of six brand-name drugs that increased in price by 500 percent or more from 2006 to 2015. In general, the mean price per milliliter of insulin increased almost 200 percent, from $4.34 per milliliter in 2002 to $12.92 per milliliter in 2013. 

© 2018 American Medical Association. All rights reserved.
High insulin prices impact stakeholders throughout the health care system. Of course, uninsured patients paying cash for their prescriptions are exposed directly to high insulin prices. Insured patients are also directly impacted by high insulin prices when they are still in the deductible period, when the drug prescribed is not covered by their insurance, when a nonpreferred formulary status for a particular insulin product leads to a higher patient cost-share, and when a Medicare Part D beneficiary is in the “donut hole.” As the number of patients enrolled in high-deductible health plans and Medicare Part D continues to rise, more patients will be vulnerable to significant drug prices. Insulin prices also impact health plans/payers and PBMs. The impact of insulin expenditures on Medicare and Medicaid has been noteworthy. For example, expenditures for just one long-acting insulin analogue, glargine, were the second largest of all Medicare expenditures in 2015. In that year, Medicare Part D spent more than $4.3 billion and Medicaid spent more than $1.4 billion on glargine alone.

Pharmaceutical manufacturers, PBMs and others in the pharmacy supply chain continue to blame each other for high drug prices, but some have taken steps that may ameliorate the impact on patients. For example, Novo Nordisk has indicated that it would limit future annual price increase percentages to not exceed single digits, ensure that a lower-priced option for human insulin remains available, and continue support of copay assistance and patient assistance programs, which are described later in this report.

At the same time, it is important to emphasize that insulin is one of the many essential drugs across all categories of pharmaceuticals—brand name, specialty, and generic—to experience remarkable price increases. For example, the brand name drug Wellbutrin XL, used to treat depression, experienced a price increase of 1,185 percent over a ten-year study period ending in 2015. Over the same ten-year study period, the specialty drug Enbrel, used to treat inflammatory and immunological disorders, experienced a 172 percent price increase. Finally, between 2010 and 2015, the generic drug divalproex sodium, an anticonvulsant, experienced a price increase of 450.6 percent. The Council acknowledges that, as with insulin, if patients are not able to take these medications correctly due to affordability, complications can result.

GOVERNMENT AND LEGAL ACTIONS TO ADDRESS INSULIN AFFORDABILITY

The significant and complicated factors contributing to increases in insulin prices have led both state and federal governments, as well as private citizens, to take formal action. To date, at least five states and a federal prosecutor are demanding information from insulin manufacturers and PBMs. In addition, prominent class-action attorneys are bringing lawsuits on behalf of patients. For example, a class action complaint filed in Massachusetts in January 2017 points to evidence that, “In 13 instances since 2009, Sanofi and Novo Nordisk raised the benchmark prices of their long-acting analog insulins, Lantus and Levemir, in tandem, ‘taking the same price increase down to the decimal point within a few days of each other’. . . Eli Lilly and Novo Nordisk have engaged in the same lock-step behavior with respect to their rapid-acting analog insulins, Humalog and Novolog.” The complaint further alleges that these pharmaceutical companies artificially inflated their list prices to secure positions on PBMs’ formularies, with PBMs demanding higher rebates in exchange for including drugs on their preferred-drug lists. Similarly, three of the main insulin manufacturers—Sanofi-Aventis, Novo Nordisk and Lilly—along with three of the largest PBMs—CVS Health, Express Scripts and OptumRx—are subject to a class action lawsuit, alleging that they together caused “rapid and lockstep price increases of more than 150 percent in insulin treatments.”

In addition, there has recently been legislative and regulatory action to improve insulin affordability. In November 2016, two US Senators requested that the Department of Justice (DOJ)
and the Federal Trade Commission (FTC) investigate possible collusion among insulin makers.\textsuperscript{20} Concerns regarding PBMs became a theme in a February 2018 hearing by the House Energy and Commerce Subcommittee on Oversight and Investigations that was focused on concentration in the health care system.\textsuperscript{21} Specifically relevant to this report, Ranking Member of the Subcommittee, Rep. Diana DeGette (D-Colo.), explored whether PBM consolidation contributed to higher prices for insulin.\textsuperscript{22} Additionally, the Food and Drug Administration (FDA) is working to “improve transparency and encourage the development and submission of abbreviated new drug applications (ANDAs) in markets with limited competition.”\textsuperscript{23} To that end, it has developed a list identifying approved new drug application (NDA) drug products that are off-patent and off-exclusivity, and for which the FDA has not yet approved an ANDA. This list of applications was updated in December 2017, and it includes several insulin products (insulin human, insulin lispro protamine recombinant, and insulin lispro recombinant).\textsuperscript{24} On the state level, in 2017, Nevada passed an act that requires the state’s Department of Health and Human Services to compile a list of prescription drugs that it determines to be essential for treating diabetes.\textsuperscript{25} The manufacturers and PBMs associated with essential diabetes drugs will have to submit annual reports to the state containing drug cost information,\textsuperscript{26} which will be analyzed by the state and reported on its website.\textsuperscript{27} However, pharmaceutical companies have begun challenging the Nevada law in court.\textsuperscript{28}

**OPPORTUNITIES TO IDENTIFY MORE AFFORDABLE ALTERNATIVES**

---

**Value-Based Insurance Design**

Value-based insurance design (VBID) uses cost-sharing as a tool to encourage the use of specific “high-value services,” which have been defined as those services that are clinically meaningful in the practice of medicine, improve quality of care or clinical outcomes for patients, and are usually standards of care as part of evidence-based guidelines or clinical care pathways.\textsuperscript{29} Unlike traditional benefit designs that apply a standard set of cost-sharing requirements to all services and all patients, VBID determines coverage and cost-sharing rules based on an assessment of the clinical value of individual health care treatments or services.

Diabetes management is an especially strong example of VBID’s potential. Aligning incentives to encourage blood glucose control prevents long-term complications from diabetes that can be physically and financially devastating to patients and the health care system. As AACE and ES have explained, without adequate control of diabetes, patients have a higher risk of developing microvascular complications such as blindness, kidney disease and nerve damage, and macrovascular complications including heart attacks and strokes.\textsuperscript{30} A recent study used actuarial modeling to predict the financial impact of VBID for Medicare beneficiaries, and it used a design that incorporated targeted reductions in cost-sharing for select chronic conditions.\textsuperscript{31} The study specifically focused on diabetes patients and included insulin and other glycemic-lowering agents among the high-value services targeted for reduced cost-sharing. The actuarial assumptions of this model indicated that removing cost-sharing for targeted high-value services would increase their use by five to 15 percent, and the fiscal impact of that additional spending would be partially offset by fewer inpatient stays and emergency department visits. The study found that for diabetes patients under this model, member cost-sharing would decrease, societal impact would be close to cost neutral, and the increase in cost to health plans would be “very modest.”\textsuperscript{32}

Recognizing its potential, VBID is gaining traction as an insurance design to improve affordability. The recently enacted Bipartisan Budget Act of 2018 incorporates the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, which includes expansion of the Medicare Advantage Value-Based Insurance Design Model to all 50 states by no later than January 1, 2020.\textsuperscript{33} The model allows Medicare Advantage plans the
flexibility to reduce cost-sharing or offer supplemental benefits to enrollees with specified chronic conditions, focusing on the services that are of highest clinical value to them. This Act demonstrates growing bipartisan support for the expanded role of VBID principles in public and private payers.

The Role of Biosimilars

Biosimilars may play a unique role in the insulin market. Currently, no insulin glargine products are licensed under the Public Health Service Act, so there is no “reference product” for a proposed biosimilar product. Instead, when Basaglar launched in December 2016, the FDA referred to it as “follow-on” insulin to the originator drug, Lantus. (This definitional confusion should resolve following a change to FDA law in 2020). As with other drugs, the price patients will pay for Basaglar varies depending on their health insurance plan. Additionally, Basaglar experienced uptake that varied based on patients’ insurance type. As of March 2017, Basaglar had achieved only approximately five percent market share. However, in the small portion of the market where insurance formularies preferred Basaglar to Lantus, it achieved approximately 50 percent market share. Notably, this year, Basaglar is preferred in Medicare Part D plans, as well as other commercial plans. Another key item to watch is a second follow-on insulin glargine, Lusduna, which gained tentative FDA approval in July 2017, but will not be issued final approval until a patent infringement suit, brought by Lantus’ maker, Sanofi, concludes. Due to stringent regulations and the cost of bringing “follow-on” or biosimilar insulins to market, some analysts expect that the mean price of insulin will not decrease as a result of “generic” competition. In contrast, other analysts have speculated that once several follow-on insulin glargine products are actively competing with Lantus and its next-generation insulin glargine brand, discounts and rebates could mean savings of approximately 30 percent, as the market niche becomes saturated.

The Role of Older Insulins

To avoid the high price of many insulin regimens, some physicians and analysts have advocated for use of older, less expensive insulins, when clinically appropriate to do so, and this may vary among patients with type 1 and type 2 diabetes. As a general principle, the more severe the insulin deficiency (for type 1 and for some type 2 diabetes), “the more important it is to have considerable mimicry of normal physiology to successfully lower glucose and do so with safety. Although not superior in overall glycemic lowering efficacy compared to human insulin, the analogs . . . have gained progressive popularity despite their increased cost. Today, analogs used as basal bolus therapy are considered the standard of care for patients who have type 1 diabetes mellitus and are increasingly used in type 2 diabetes.”

In fact, the proportion of patients using more expensive, newer insulin analogs has substantially increased, even though data suggests that there is “little clinical benefit” to using insulin analog versus regular human insulin and neutral protamine Hagedorn (NPH) for type 2 diabetes. In 2000, 19 percent of privately insured adults with type 2 diabetes were using analog insulin, but by 2010, 96 percent of that population was using insulin analogs. The older insulins, however, are still considered to be as effective as the analogs in controlling blood glucose for most patients with type 2 diabetes. Moreover, a vial of NPH (N), human regular (R), or premixed 70/30 N/R insulin (Novolin N, R, or 70/30) can be obtained for as little as $25. At the same time, given the substantial increase in use of insulin analogs since 2000, younger clinicians may not be as well versed in the use of older insulins, with many training programs no longer emphasizing the use of human insulins. Accordingly, guidance and educational materials can help younger physicians become more comfortable with prescribing more affordable insulin alternatives.
other high-income countries and found that US citizens consume a mix of drugs that include a high proportion of newer, more expensive medications without evidence of better health outcomes than the other nine countries examined. The study observed that, unlike the US, the other nine countries have processes to assess not just whether a new drug is effective, but whether it is more effective than existing therapies, and sometimes, whether it is cost-effective. A process for including cost-effectiveness in comparative effectiveness research for pharmaceuticals is consistent with AMA Policy H-110.986, which is detailed in the policy section below.

Improving Price Transparency

With timely, accurate information about what a specific prescription will cost a specific patient, physicians and patients will be in a stronger position to jointly develop optimal treatment plans. As detailed below, the AMA is engaged in significant activity, supported by longstanding policy, to advocate for improved prescription drug price transparency. Improved transparency at the point of sale may also help patients address affordability concerns.

Many health care industry stakeholders can potentially help improve insulin affordability. In November 2017, Surescripts announced a Real-Time Prescription Benefit to advance this goal. Surescripts is collaborating with six electronic health records (EHR) companies (representing 53 percent of the US physician base) and leveraging information from PBMs CVS Health and Express Scripts (representing nearly two-thirds of US patients), “to deliver patient-specific benefit and price information to providers in real time at the point of care. Once integrated with the EHR, the solution will also display therapeutic alternatives so that the prescriber and patient can collaborate in selecting a medication that is both clinically appropriate and affordable.” UnitedHealthcare and OptumRx are collaborating to provide a similar tool, specifically for their enrollees. With PreCheck MyScript, before prescribing a medication, physicians can run a pharmacy trial claim to see how much a patient would be charged for a specific medication. The system will also provide lower-cost alternatives, when available.

In addition, pharmacists play an important role. Pharmacists may be aware of less expensive prescription drug options, but pharmacists can be prevented from informing patients of these options due to certain provisions in their contracts with PBMs. For example, a drug formulary can require patients to spend more on a prescription copay than they would be charged if they purchased the drug without insurance. So called “gag clauses” in pharmacy-PBM contracts can bar pharmacists from telling consumers about less expensive options, such as not using their insurance. Moreover, “clawback” provisions can allow PBMs to take back the difference between a higher copay amount and a lower negotiated rate. Bipartisan bills have recently been introduced in both the Senate and the House to prohibit these restrictions on pharmacies and pharmacists.

Additionally, financial assistance programs can help eligible patients, but as the ES has explained, these programs are often inaccessible or overly complicated for the patients who need them the most. For example, the Novo Nordisk Savings Card can help patients save hundreds of dollars on their diabetes medication. However, to be eligible for this program, patients must be enrolled in a commercial insurance plan (patients paying cash and those insured through any federal or state plan are ineligible). Additionally, the discount only applies for up to 24 months, and is subject to maximum benefit limitations. Sanofi-Aventis similarly offers a Sanofi Rx Savings Card, but it too carries eligibility restrictions that are not easily found on its website. Finally, Lilly offers limited time offers for discounts on insulin products, but each offer is subject to eligibility requirements and differing expiration dates.
Some patients may benefit from other forms of financial assistance, but this too is complicated. Patients without health insurance or without prescription drug coverage can apply for patient assistance programs, and the nonprofit NeedyMeds can help patients find programs that offer free or low-cost insulin for those who meet eligibility requirements. Some patients who have prescription drug coverage, especially those with high deductible health plans, may find that cash and coupon prices can be lower than their insurance copay or coinsurance. Websites like GoodRx can help patients find the lowest prices for their insulin. However, companies that provide health insurance and prescription drug coverage have started instituting “copay accumulators,” which can significantly impact patients’ out-of-pocket costs when using drug coupons. Previously, when patients used copay coupons to reduce the price they pay for their prescriptions, the value of those coupons counted toward their deductible or out-of-pocket maximum. However, the new copay accumulators will not count the coupons’ value toward helping patients spend down their deductibles and out-of-pocket maximum. Accordingly, once patients use the full value of their drug coupons, they will be subject to more of the cost than they had been before. Moreover, some insurance companies limit insured patients’ abilities to use prescription coupons at all.

AMA POLICY AND ADVOCACY

Extensive AMA policy and highly visible AMA advocacy directly respond to the resolves of referred Resolution 826-I-17 and continue to strive for greater prescription drug cost transparency and affordability.

AMA Policy

The Council agrees with the AACE and ES that a key issue in addressing insulin affordability is working toward reduced patient cost-sharing. AMA policy has historically strongly supported VBID, which can achieve reduced patient cost-sharing. For example, Policy H-155.960 encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. The policy stipulates that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. Policy H-185.939 outlines principles to guide the design and implementation of VBID programs, stating that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements, and that coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Supporting the role of physicians in engaging patients in joint decision-making to select an insulin regimen that appropriately balances clinical needs and cost-effectiveness, Policy H-450.938 stipulates that the cost of alternate interventions, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated. Moreover, the policy states, physicians should encourage their patients to participate in making value-based health care decisions.

AMA policy also supports value-based pricing for pharmaceuticals (Policy H-110.986). The policy specifically calls for value-based pricing processes that incorporate affordability criteria and that include cost-effectiveness analyses in comparative effectiveness research. Similarly, Policy H-110.990 states that cost-sharing requirements for prescription drugs should be based on considerations such as the unit cost of medication, availability of therapeutic alternatives, medical condition being treated, personal income, and other factors known to affect patient compliance. Finally, Policy H-125.977 advocates for economic assistance, including coupons and other discounts for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured.
Another key to improving insulin affordability is improving price transparency. Consistent with Resolution 826-I-17 and ES recommendations, Policy H-125.979 supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, and that drugs may not be removed from the formulary or moved to a higher cost tier within the policy term. Additionally, the AMA developed model state legislation entitled, “An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year” (AMA Model Act), and it directly addresses the issue of stabilized formularies and cost transparency. The AMA Model Act specifically responds to Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs and health insurance companies. The policy also supports drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase, and legislation that authorizes the Attorney General and/or the FTC to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients. In addition, the policy encourages FTC actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. Also, Policy H-110.991 advocates for greater prescription drug price transparency at the pharmacy point of sale by: (1) advocating that both the retail price and the patient’s copay be listed on prescription receipts, (2) pursuing legislation that would require pharmacies to inform patients of the cash price as well as the formulary price of any medication prior to purchase, and (3) opposing provisions in contracts between pharmacies and PBMs that would prohibit pharmacies from disclosing when a patient’s copay is higher than the drug’s cash price.

Physicians will be in a stronger position to help their patients with insulin affordability concerns if information systems can integrate price information, thus empowering physicians and patients to make informed decisions at the point of prescribing. The AMA Model Act also addresses the issue of timely decision support, consistent with Policy H-450.938, which states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. In addition, the policy calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and useable evidence and information at the point of decision-making. Related, Policy H-125.979 encourages PBMs, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide. Similarly, Policy H-110.990 supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can jointly decide on treatment.

Several AMA policies support the FDA’s efforts to highlight drugs that are off-patent and off-exclusivity. Specifically, Policy H-100.980 supports a strong and adequately funded FDA to ensure that safe and effective medical products become available as efficiently as possible. The policy also states that our AMA will continue to work with the FDA on controversial issues concerning drugs, biologics and pharmaceuticals to try to resolve concerns of physicians. Related, Policy H-125.984 states that Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process. Finally, Policy H-125.980 supports FDA implementation of the Biologics Price Competition and Innovation Act of 2009 in a manner that places appropriate
emphasis on promoting patient access, protecting patient safety, and preserving market competition
and innovation.

Also noteworthy are the many policies establishing a framework for the AMA’s approach to
improving drug pricing. For example, Policy H-110.998 urges the pharmaceutical industry to
exercise reasonable restraint in the pricing of drugs. Policy D-110.993 states that our AMA will
continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in
effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the
pricing of drugs. Policy H-110.992 states that the AMA will monitor the relationships between
PBMs and the pharmaceutical industry and will strongly discourage arrangements that could cause
a negative impact on the cost or availability of essential drugs. Policy H-110.997 supports
programs to contain the rising costs of prescription drugs that meet certain criteria, and encourages
physicians to consider prescribing the least expensive drug.

Policy H-155.962 opposes the use of price controls in any segment of the health care industry, and
continues to promote market-based strategies to achieve access to and affordability of health care
goods and services. However, AMA policy makes a departure from its market-based approach to
pharmaceutical pricing in Policy D-330.954, which supports federal legislation that gives the
Secretary of the Department of Health and Human Services the authority to negotiate contracts
with manufacturers of covered Part D drugs. The policy also states that our AMA will work toward
eliminating the Medicare prohibition on drug price negotiation.

AMA Activity

AMA Model Legislation: The AMA Model Act referenced previously provides a template that
state legislatures can modify to increase prescription drug cost transparency in a variety of ways,
and it specifically advances many of the goals of Resolution 826-I-17 with regard to price and cost
transparency, as well as integration into EHRs. Specifically, under the AMA Model Act,
manufacturers of prescription medication available in any state that implements this act would be
required to disclose a variety of their costs, as well as the amount of financial assistance they
provide to patients; health insurers and PBMs operating in the state would be required to disclose
any discounts or other financial consideration they received that affects the price and cost-sharing
of covered medicines placed on a formulary. Consistent with ES recommendations, the AMA
Model Act would also authorize a pilot study to integrate transparency data at the point of care,
with information such as medicines’ formulary status, cost-sharing tier, patient out-of-pocket cost,
and coverage restrictions (eg, prior authorization, step therapy, quantity limits) being integrated
into the clinical and prescribing workflows of physicians and other health care providers in EHR or
electronic prescribing systems. Finally, consistent with Policy H-110.991, the AMA prepared a
new model bill that prohibits clawbacks and standard gag clauses in pharmacy-PBM contracts.
Several states have enacted and/or are considering similar legislation, and with its new model bill,
the AMA will advocate for greater nation-wide adoption of such policies.

AMA State and National Engagement: The AMA has been engaged in legislative and regulatory
advocacy concerning prescription drug pricing and costs. For example, in December 2017, the
AMA testified at a hearing of the Health Subcommittee of the House Committee on Energy and
Commerce on examining the pharmaceutical supply chain. The AMA has been engaged at the
National Association of Insurance Commissioners as it develops its Prescription Drug Benefit
Management Model Act, including with regard to mid-year formulary changes. On the state level,
in 2017, the AMA supported Assembly Bill 762 in New Jersey, which would help provide patients
and the legislature with relevant information about the manufacturing, production, research and
development, advertising and other associated costs for prescription medications. Additionally, the AMA continues to urge state medical associations to have the AMA Model Act introduced.

AMA Grassroots Campaign: Pursuant to Policy H-110.987, and consistent with Resolution 826-I-17, in 2016, the AMA convened a Task Force on Pharmaceutical Costs, which met four times to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs. The Task Force agreed that increasing transparency among pharmaceutical companies, health plans and PBMs should be the first focus of the grassroots campaign, which led to the launch of the TruthinRx campaign in 2016. The goal of TruthinRx is to expose the opaque process that pharmaceutical companies, PBMs, and health plans engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency. To date, over 150,000 individuals have signed a petition to members of Congress in support of greater drug pricing transparency. Additionally, the TruthinRx.org website provides a template letter that website visitors can customize and directly send to their US Senators and US Representatives, calling on them to support increased transparency in prescription drug prices. Finally, the Council notes that the TruthinRx.org website has content specifically addressing insulin pricing. Continuously updated to reflect advances in AMA policy and pharmaceutical industry activities.

DISCUSSION

The Council lauds the sponsors of Resolution 826-I-17 for highlighting the price increases of insulin and shares the concerns that have led to class action lawsuits, state and federal actions, and congressional requests that the DOJ and FTC investigate possible collusion among insulin makers. The market factors contributing to the insulin price increases are complex and span the pharmaceutical supply chain. Pursuant to Policy H-110.992, the AMA is committed to monitoring the relationships between PBMs and the pharmaceutical industry and strongly discouraging arrangements that could cause a negative impact on the cost or availability of essential drugs. In addition, Policy H-110.987 supports legislation that authorizes the Attorney General and/or the FTC to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients. Building upon these policies, the Council recommends that the AMA encourage the FTC and DOJ to monitor insulin pricing and market competition and take enforcement actions, as appropriate.

As demonstrated by the extensive policy and activity summarized in this report, the AMA is deeply committed to efforts to improve prescription drug affordability in general, and insulin affordability, in particular. In addition to supporting the FTC and DOJ, the AMA has established policy that supports the FDA as it strives to increase access to high quality generic and biosimilar drugs. Specifically, under Policy H-100.980, the AMA affirms its commitment to continuing to work with the FDA on controversial issues concerning drugs, biologics and pharmaceuticals to try to resolve concerns of physicians.

VBID presents a powerful opportunity to reduce patient cost-sharing for high-value services, such as diabetes treatment, and AMA policy strongly supports this model. Policy H-185.939 outlines principles to guide the design and implementation of VBID programs, including that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements. Policy H-110.986 specifically supports value-based pricing for pharmaceuticals, and Policy H-155.960 encourages third-party payers to use targeted benefit design, with cost-sharing requirements determined based on the clinical value of a health care service, with consideration given to patient income and other factors known to impact compliance. Similarly, Policy H-110.990 states that cost-sharing requirements for prescription
drugs should be based on considerations such as the unit cost of medication, availability of therapeutic alternatives, medical condition being treated; personal income, and other factors known to affect patient compliance. In addition, the policy supports joint physician-patient decision-making, encouraging the development and use of technology to enable physicians and patients to determine the actual price and out-of-pocket costs of prescription drugs prior to making prescribing decisions.

In recent years, the AMA has demonstrated an ongoing commitment to improving prescription drug price transparency. As detailed above, the TruthinRx campaign continues a powerful grassroots campaign for greater transparency in prescription drug pricing, and the AMA Model Act specifically responds to Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs, and health insurance companies. Moreover, pursuant to Policy H-110.987, the AMA supports drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase. Similarly supporting transparency and collaboration across the pharmacy supply chain, Policy H-125.979 supports AMA efforts to encourage PBMs, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing. In this way, health care technology and shared information can promote optimal physician-patient joint decision making. Together, these efforts are accomplishing the goals of Resolution 826-I-17. As a logical next step, the Council recommends that the AMA disseminate the model state legislation it has developed to promote increased drug price and cost transparency and to prohibit “clawbacks” and standard gag clauses in contracts between pharmacies and PBMs that bar pharmacists from telling consumers about less expensive options, such as choosing to pay cash rather than using insurance, to purchase their medication. Moreover, the Council recommends that the AMA provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

The Council also thanks the AACE and the ES for their expertise and for calling attention to the need for training on the appropriate use of regular human insulin and neutral protamine Hagedorn for post-graduate physicians, fellows, residents, and students. The Council recommends that the AMA support initiatives, such as those by AACE, ES, and other national medical specialty societies, that strive to fill this gap in continuing medical education. Similarly, to help physicians better understand the complex challenges their patients may face in paying for their medication, the Council recommends that the AMA support physician education regarding drug price and cost transparency and challenges that arise at the pharmacy.

As described above, it is important to continue to view insulin affordability within the context of the much broader issue of prescription drug affordability in the US. The AMA has a deep and longstanding commitment to improving patient access to affordable prescriptions. Recognizing that access to critical drugs across many critical disease states is jeopardized by high prices and continued price increases, the AMA has made a strategic decision to work toward broad-based reforms, rather than to examine one disease state or drug at a time. Otherwise, the AMA would be in a position to require individual summits and advocacy campaigns that are unique to each of the critical pharmaceutical challenges facing AMA members and their patients, which would not be a sustainable advocacy model. Accordingly, the Council’s recommendations encourage continued AMA leadership on a broad strategy to address pharmaceutical pricing, while supporting initiatives to improve the affordability of insulin for our patients.
RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 826-I-17, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate. (New HOD Policy)

2. That our AMA disseminate model state legislation to promote increased drug price and cost transparency and to prohibit “clawbacks” and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication. (Directive to Take Action)

3. That our AMA provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency. (Directive to Take Action)

4. That our AMA support physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale. (New HOD Policy)

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

6. That our AMA reaffirm Policy H-110.992, which states that the AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies; supports drug price transparency legislation that requires public notice by pharmaceutical manufacturers when certain price increase triggers are reached; and supports legislation that authorizes the Attorney General and/or the FTC to take legal action to address price gouging by pharmaceutical manufacturers and increase patient access to affordable drugs. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-100.980, which states that the AMA will continue to work with the Food and Drug Administration on controversial issues, including those concerning drugs, biologics, and pharmaceuticals, to try to resolve concerns of physicians. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-125.979, which supports legislation or regulation to ensure that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term. (Reaffirm HOD Policy)
10. That our AMA reaffirm Policies H-185.939, H-155.960 and H-110.986 which support value-based insurance design and value based pricing for pharmaceuticals. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-110.990 which supports cost-sharing requirements for prescription drugs that consider factors known to affect patient compliance and the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of prescription drugs prior to making prescribing decisions. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


3 Letter from the American Association of Clinical Endocrinologists and the Endocrine Society to Paul Wertsch, MD, Council on Medical Service Chair. February 27, 2018.


5 Id.


9 Id.


16 Id.


18 Id.


22 Id.


24 Id.


26 Id.

27 Id.


31 Id.

32 Id.


37 Id.

38 Id.


45 Id.
46 Id.
48 Id.
51 Id.
55 Id.
57 H.R.5343, 115th Congress (2017-2018), To amend the Public Health Service Act to nullify certain contractual provisions prohibiting or penalizing a pharmacist's disclosure of the availability of therapeutically equivalent alternative drugs, or alternative methods of purchasing the prescription drug, that are less expensive, and for other purposes. Introduced 3-20-18. Available at: https://www.congress.gov/bill/115th-congress/house-bill/5343/text. Accessed 3-27-18.
58 Letter from the American Association of Clinical Endocrinologists and the Endocrine Society to Paul Wartsch, MD, Council on Medical Service Chair. February 27, 2018.
60 Id.
61 Id.

See also: GoodRx. Insulins. Available at: https://www.goodrx.com/insulins. Accessed 2-12-18.


Id.


Letter from the American Association of Clinical Endocrinologists and the Endocrine Society to Paul Wertsch, MD, Council on Medical Service Chair. February 27, 2018.

Letter from the American Association of Clinical Endocrinologists and the Endocrine Society to Paul Wertsch, MD, Council on Medical Service Chair. February 27, 2018.


APPENDIX

Policies Recommended for Reaffirmation

H-100.980 Food and Drug Administration
(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible.
(2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency’s ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate.

H-110.986 Incorporating Value into Pharmaceutical Pricing
1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.
2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

H-110.987 Pharmaceutical Costs
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

H-110.990 Cost Sharing Arrangements for Prescription Drugs
Our AMA:
1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition.

H-110.992 Study of Actions to Control Pharmaceutical Costs
Our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs.
H-125.979 Private Health Insurance Formulary Transparency

1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.

2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.

3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term.

4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.

5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.

6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.

7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.

8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.


H-155.960 Strategies to Address Rising Health Care Costs

Our AMA:

(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;

(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote “value-based decision-making” at all levels;

(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;

(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;

(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at
the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;

(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;

(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and

(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.

(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.


H-185.939 Value-Based Insurance Design

Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles: (a) Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.

(b) Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.

(c) High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan. (d) The methodology and criteria used to determine high or low-value services or treatments must be transparent and easily accessible to physicians and patients. (e) Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design. (f) VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices. (g) Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties. (h) Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence. (i) VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H450.941 and D285.972). Policy Timeline CMS Rep. 2, A13 Reaffirmed in lieu of Res. 122, A15 Reaffirmed in lieu of: Res. 121, A16 Reaffirmed: CMS Rep. 05, I-16 Reaffirmation I-16
Joint Report of the Council on Medical Service
And the Council on Science and Public Health

CMS/CSAPH Joint Report A-18

Subject: Coverage for Colorectal Cancer Screening
(Resolution 822-I-17)

Presented by: Paul Wertsch, MD, Chair, Council on Medical Service
Robert A. Gilchick, MD, MPH, Chair, Council on Science and Public Health

Presented to: Reference Committee A
(Jonathan D. Leffert, MD, Chair)

At the 2017 Interim Meeting, the House of Delegates referred Resolution 822, “Elimination of All Cost-Sharing for Screening Colonoscopies,” which was sponsored by the Georgia Delegation. The Board of Trustees assigned this item to the Council on Medical Service (CMS) and the Council on Science and Public Health (CSAPH) for a report back to the House of Delegates at the 2018 Annual Meeting. Resolution 822 asked: That the American Medical Association (AMA) develop model national policy that supports the voluntary removal of all cost-sharing associated with screening colonoscopies in all commercial and Medicare Advantage product lines and advocate for the adoption of these policies nationwide.

This report explains sources of confusion regarding insurance coverage for colorectal cancer screening (CRCS), summarizes relevant AMA policy and advocacy, and presents policy recommendations. The Councils developed this report in the context of a broader joint report they are preparing for the 2018 Interim Meeting regarding improving alignment of cost-sharing incentives for high-value services, such as CRCS.

BACKGROUND

The American Cancer Society estimates that colorectal cancer will be the third leading cause of cancer deaths among men and women in the US in 2018.1 If a colorectal cancer patient is diagnosed with localized-stage disease, the five year survival rate is 90 percent, but unfortunately, only 39 percent of colorectal cancer patients are diagnosed at this early stage.2 CRCS reduces colorectal cancer mortality both by decreasing the incidence of disease and by increasing the likelihood of survival.3

United States Preventive Services Task Force (USPSTF) CRCS Recommendation

In June of 2016, the USPSTF published a final recommendation on colorectal cancer screening. The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.4 The recommendation received an “A” grade, meaning that the USPSTF recommends the service and there is high certainty that the net benefit is substantial.

The screening methods examined by the USPSTF included stool based tests: guaiac-based fecal occult blood test (gFOBT), fecal immunochemical tests (FITs), and multitargeted stool DNA...
testing (FIT-DNA) as well as direct visualization tests: colonoscopy, flexible sigmoidoscopy, CT colonography, and flexible sigmoidoscopy with FIT. The USPSTF noted that risks and benefits of different screening methods vary. However, given the lack of evidence from head-to-head comparative trials that any of the screening strategies have a greater net benefit than the others, the USPSTF encourages clinicians to engage patients in informed decision-making about the screening strategy that would most likely result in completion, with high adherence over time, taking into consideration both the patient’s preferences and local availability.

**Barriers to Screening**

Despite the large body of evidence indicating the effectiveness of CRCS and the variety of screening options available, one in three people are not up to date with CRCS. Barriers to CRCS are more common among people with fewer financial resources, leading to disparities in care. Moreover, there is substantial evidence that inadequate insurance coverage is associated with lower rates of screening. Insurance coverage advances under the Affordable Care Act (ACA) tried to address under utilization rates of CRCS, but coverage of CRCS is uniquely complex, which poses barriers to care.

Coverage of CRCS, including colonoscopies, has been fraught with confusion and consternation for two key reasons. First, a colonoscopy is a rare example of how a single service can inherently incorporate screening, diagnosis, and treatment. In just one colonoscopy, an asymptomatic patient could be screened and one or more concerning polyp(s) removed for biopsy, making insurance coverage of CRCS uniquely confusing. This report both explains what leads to this confusion and makes recommendations regarding how the confusion can be ameliorated.

Second, CRCS suffers from misaligned incentives and expectations in much the same way as many other valuable preventive interventions. While CRCS is provided without cost-sharing for asymptomatic adults 50 years and older who are at average risk of colorectal cancer, it is arguably more valuable that higher-risk individuals be screened and with greater frequency to detect more likely instances of deadly disease at earlier stages. Moreover, for both clinical and financial reasons, a prudent approach can be to initiate CRCS with a non-invasive stool test, and only subject patients to invasive colonoscopies when the procedure is required for complete screening, diagnosis, and/or treatment. Patient cost-sharing models should encourage less invasive screening first, when appropriate, but they currently may not. Similar logic applies to other cancer screenings, management of chronic conditions, etc. This broader issue of aligning incentives for preventive interventions will be explored in detail in the aforementioned joint report of the CMS and the CSAPH at I-18.

**Coverage Varies by Insurance**

ACA – Commercial Insurance: The Councils previously considered preventive services in CMS/CSAPH Joint Report A-17, “Value of Preventive Services,” and explained that the ACA tasked four expert organizations with identifying the preventive services that will be provided with no patient cost-sharing under all private, non-grandfathered health insurance plans. One of these expert organizations is the USPSTF, and the ACA mandates coverage of all of its “A” and “B” recommended services. Despite receiving an “A” recommendation from the USPSTF, implementation of the CRCS recommendation has resulted in confusion. Two key areas have raised concerns: (a) the population included in the no cost-share benefit and (b) the extent of the services included in the no cost-share benefit.
Regarding the population included in the no cost-share benefit, the USPSTF provides some guidance that clarifies implementation of its recommendation. The USPSTF did not review the evidence on screening populations at increased risk, so the recommendation does not speak to such patients. Specifically, the USPSTF states that its recommendation applies to:

[A]symptomatic adults 50 years and older who are at average risk of colorectal cancer and who do not have a family history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer . . . , a personal history of inflammatory bowel disease, a previous adenomatous polyp, or previous colorectal cancer. When screening results in diagnosis of colorectal adenomas or cancer, patients are followed up with a surveillance regimen, and recommendations for screening no longer apply.11

The USPSTF guidance effectively eliminates vulnerable portions of the population from the valuable no cost-share screenings (eg, individuals who have an elevated risk of colorectal cancer, a history of previous adenomatous polyp, or who are otherwise being followed with a “surveillance regimen.”) At the same time, the USPSTF also acknowledges the critical importance of CRCS for individuals at-risk: “[T]his recommendation applies to all racial/ethnic groups, with clear acknowledgment that efforts are needed to ensure that at-risk populations receive recommended screening, follow-up, and treatment.”12 With at-risk populations carved out of the USPSTF recommendation, it is not clear how the needed screening, follow-up, and treatment can be incentivized.

Regarding the extent of services included in the no cost-share benefit, the federal government seemed to recognize that the USPSTF recommendation was vulnerable to confusion when it issued clarifying guidance in 2013. Specifically, guidance prepared jointly by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) state that cost-sharing may not be imposed when a polyp is removed during a screening colonoscopy pursuant to the USPSTF recommendation:

Based on clinical practice and comments received from the American College of Gastroenterology, American Gastroenterological Association, American Society of Gastrointestinal Endoscopy, and the Society for Gastroenterology Nurses and Associates, polyp removal is an integral part of a colonoscopy. Accordingly, the plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. On the other hand, a plan or issuer may impose cost-sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.13

The Departments’ guidance demonstrates how clinical insight from the physicians responsible for delivering a preventive intervention can lead to better alignment between clinical need and insurance coverage. Similarly, medical experts have described screening not as a single test, “but rather a cascade of events” – a stepwise continuum that may begin with a clinician’s recommendation that an asymptomatic patient receive testing and conclude with the outcome of the test(s).14 The Departments’ guidance seems to reflect this “cascade of events” understanding, but confusion surrounding patient cost-sharing for CRCS persists, nevertheless.

While the USPSTF updated its screening for colorectal cancer recommendation in 2016, the updated recommendation hints at, but does not embrace, the “cascade of events” understanding of preventive screening. The recommendation expressly acknowledges that colonoscopy “represents the primary source of harms associated with CRCS,”15 seemingly suggesting that less-invasive tests could represent a safe starting point for screening. Moreover, the recommendation acknowledges
that “with all screening methods, positive findings lead to follow-up colonoscopy.” To embrace screening that acknowledges a “cascade of events,” the USPSTF could have specified that if a less-invasive screening test is used as a first line preventive method, and that initial test is positive, a colonoscopy should be used to complete the screening process. Including such explicit clarification in its recommendation would ensure that the entire “cascade of events” critical to effective CRCS is included among the ACA benefits provided without cost-sharing. The absence of this clarification contributes to the implementation challenges outlined below.

Medicare: Medicare provides significantly more detailed information about coverage of CRCS. However, as highlighted by HR 1017 and the AMA’s support of that legislation, Medicare coverage differs critically from commercial coverage. Specifically, when a polyp or abnormal growth is removed during a colonoscopy, or when a biopsy is done of suspicious-looking tissue, the “screening” colonoscopy becomes “diagnostic,” and although the Medicare Part B deductible is waived, beneficiaries are billed co-insurance of 20 percent of the cost of the procedure. This can lead to significant confusion, misaligned expectations, patient financial burden, and patient avoidance of CRCS.

Implementation Challenges

Given the complicated coding and payment rules surrounding CRCS, it is unsurprising that patients commonly find themselves billed for services they expected to be covered at no cost to them. As a result, health care providers, payers and government agencies can field a significant volume of questions and complaints.

The following are some situations where patients have reported being unexpectedly charged for elements of CRCS:

- If a patient receives a colonoscopy following a positive result in a stool test (such as gFOBT or FIT) or an abnormal double-contrast barium enema or CT colongraphy, patients may incur cost-sharing.
- If a patient is classified as “high-risk” for colorectal cancer, that patient’s colonoscopy could incur cost-sharing, whereas the same procedure would be free of cost-sharing for an “average risk” peer.
- If a Medicare patient underwent what was thought to be a preventive screening colonoscopy (ie, no cost-sharing), and polyps were removed during the procedure, the patient may be surprised to incur cost-sharing.

Definition, Coding and Payment

There is significant confusion and inconsistency in how preventive interventions, particularly CRCS, are defined, coded and paid, potentially negatively impacting patient care. Whether a colonoscopy is called “screening,” “diagnostic,” or “therapeutic” can be subjective, and although such classification may not be clinically important, the classification can have a significant financial effect on the patient. Moreover, fear of financial burden may cause patients to forgo necessary care or force them to cope with adverse financial ramifications. Finally, without a common vocabulary that is universally understood among clinicians and payers (and effectively translated to patients), misunderstanding and misaligned expectations are a natural and unfortunate result.
AMA POLICY AND ADVOCACY

The AMA has established a priority of supporting evidence-based preventive services. Policy H-165.840 advocates for evidence-based prevention insurance coverage for all patients, and in all appropriate venues. Policy H-185.960 specifically advocates for health plan coverage of the full range of CRCS. Moreover, Policy D-330.950 supports Medicare coverage for a physician consultation prior to a screening colonoscopy. Echoing the “cascade of events” philosophy, Policy H-425.994 emphasizes the importance of only pursuing testing in patients when adequate treatment and follow-up can be arranged for identified abnormal conditions and risk factors.

Several AMA policies promote education of physicians and the public regarding the benefits of preventive interventions, the continued availability of such services, and insurance coverage of such services, including: H-165.848 supporting a requirement that preventive health care be included in the minimal coverage available to all families; H-425.986 encouraging communication and cooperation among physicians and public health agencies to address challenges in preventive medicine; and Ethical Opinion 8.11 encouraging physicians to keep current with preventive care guidelines. Finally, Policy H-450.938 sets forth Principles to Guide Physician Value-Based Decision-Making and specifically emphasizes that physicians should seek opportunities to integrate prevention, including, screening, testing and lifestyle counseling, into patient office visits.

Various AMA policies call for first-dollar coverage (payment exclusively by the health plan), including: H-185.969 regarding immunizations, D-330.935 regarding Medicare preventive service benefits, and H-290.972 regarding preventive coverage for health savings account holders in the Medicaid program. Policy D-425.992 demonstrates the potentially negative impact that limiting USPSTF recommended services can have on access to preventive care (in this case, access to screening mammography and prostate specific antigen [PSA] screening). At the same time, Policy H-165.856 calls for benefit mandates to be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

Several AMA policies directly support the goals articulated throughout this report. Specifically, Policy D-330.967 advocates for continued collaboration with national medical specialty societies and interest groups in the context of evidence-based recommendations regarding preventive services, especially for populations at high risk for a given condition. Similarly, Policy H-390.849 advocates for physician payment reform consistent with promoting improved patient access to high-quality, cost-effective care; promoting designs that incorporate input from the physician community; and providing patients with information and incentives to encourage appropriate utilization of preventive services. AMA policy also focuses specifically on the needs of Medicare beneficiaries in this context. Policy D-330.935 states that the AMA will collaborate with relevant stakeholders, including appropriate medical specialty societies, to actively promote to the public and the profession the value of Medicare-covered preventive services and it will support the expansion of first-dollar coverage for a preventive visit and required tests anytime within the first year of enrollment in Medicare Part B. Finally, Policy H-425.992 advocates for revision of current Medicare guidelines to include coverage of appropriate preventive medical services.

In addition, the AMA is engaged in advocacy initiatives to improve Medicare coverage of CRCS. On October 6, 2017, the AMA sent letters to Senator Sherrod Brown (D-OH) and Representative Charlie Dent (R-PA) in support of HR 1017, “Removing Barriers to Colorectal Cancer Screening Act of 2017.” HR 1017 would level the playing field across ACA-compliant commercial health insurance plans and Medicare, waiving coinsurance under Medicare for CRCS, regardless of whether therapeutic intervention is required during the screening. The passage of HR 1017 would therefore address current significant barriers to care for the Medicare population.
DISCUSSION

The misaligned expectations surrounding coverage for CRCS drive toward three key opportunities for improvement: (1) pursue changes to benefit design that better align reduced cost-sharing with high-value services; (2) promote common understanding among health care providers, payers, and patients so that all know what will be covered at given cost-sharing levels; and (3) advocate for Medicare coverage consistent with ACA-compliant plan coverage.

Recognizing that much can be done to better align reduced cost-sharing with high-value services that prevent advanced disease, the CMS and CSAPH agreed to the development of a joint Council-initiated report for I-18, and this report will speak to the first opportunity referenced above. The I-18 CMS/CSAPH joint report will develop consistent and broadly applicable policy that addresses not only the CRCS concerns raised in Resolution 822, but also concerns about access to high-value preventive interventions in general. The Councils plan to expand upon their prior report regarding coverage for preventive services, and they are committed to advocating for changes to benefit design that better align reduced cost-sharing with high-value services.

The second opportunity referenced above is ripe for AMA educational leadership. The complexities in coding CRCS as a USPSTF-recommended preventive service vs. “surveillance” for ACA-compliant plans, and “screening” vs. “diagnostic” for Medicare plans, necessitate reliable coding guidance. The Councils acknowledge that there is currently conflicting guidance issued by credible specialty organizations on this topic. The AMA, as the authority on CPT, is in a unique position to issue educational materials that can be seen as a source of truth in aligning CRCS clinical scenarios to the proper CPT codes for billing. Accordingly, per Recommendation 7, the AMA will collaborate with physicians who specialize in CRCS to develop a coding guide to help physicians correctly bill various CRCS scenarios. A component of this coding guide will encourage specialist physicians to develop additional educational materials consistent with the guide and encourage both the health care provider and public health communities to continue efforts to educate the public about the value of CRCS.

As described above in the context of AMA advocacy with respect to HR 1017, the AMA is already actively engaged in efforts to address some of the challenges in Medicare coverage for CRCS, and thus already working toward the third opportunity above. Similarly, as described above, the AMA has several policies that firmly support the goals of this report. Accordingly, it is recommended that policies D-330.935, D-330.967, H-185.960, H-390.849, and H-425.992 be reaffirmed. In addition, in Recommendation 6, the Councils support a new policy to codify on-going support of efforts to align coverage under Medicare and ACA-compliant health plans for CRCS.

In Recommendation 8, the Councils propose amending existing policy regarding appropriate screening programs to delete reference to specific types of screening. Since the evidence-base for screening evolves over time, the Councils do not feel it is prudent to outline specific types of screening within AMA policy.

RECOMMENDATIONS

The Council on Medical Service and the Council on Science and Public Health recommend that the following be adopted in lieu of Resolution 822-I-17, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-330.935, which supports AMA collaboration with relevant stakeholders, including medical specialty societies, to actively promote to the public and the profession the value of Medicare-covered preventive
services, and supports first-dollar coverage under Medicare for preventive visits and required tests. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-330.967, which supports continued collaboration with national medical specialty societies and interest groups in the context of evidence-based recommendations regarding preventive services and especially the provision of preventive services to populations at high risk for a given condition. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-185.960, which advocates for health plan coverage of the full range of colorectal cancer screening tests. (Reaffirm HOD Policy)

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

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

6. That our AMA continue to support Medicare coverage for colorectal cancer screenings consistent with ACA-compliant plan coverage requirements. (New HOD Policy)

7. That our AMA encourage the development of a coding guide to help providers appropriately bill for various colorectal cancer screening services and promote common understanding among health care providers, payers, and patients so that all know what will be covered at given cost-sharing levels. (Directive to Take Action)

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

Our AMA supports: (1) Appropriate screening programs to detect colorectal cancer in individuals who are older than 50 years of age or have risk factors. (2) The general recommendations of major health care organizations for colorectal cancer (CRC), which are as follows: annual fecal occult blood testing, beginning at age 50, and flexible sigmoidoscopy every 3 to 5 years from age 50, for persons at average risk. Colonoscopy and/or double-contrast barium enema procedures, which screen the entire colon, should be considered as appropriate alternatives. (3) Persons at increased risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) receiving more intensive screening efforts. (4) Physicians becoming aware of genetic alterations that influence the development of CRC, and of diagnostic and screening tests that may become are available in this area. (Modify Current HOD Policy)

Fiscal Note: Less than $2,000.
REFERENCES


3 Id.


5 Id.

6 Id.

7 Supra note 2.


9 Supra note 1.


12 Id.


15 Supra note 11.

16 Supra note 11.
Whereas, The concepts of pluralism and patient choice in the healthcare payment system are long standing AMA policy (D-330.924, H-165.844, H-390.854), and

Whereas, The Medicaid healthcare payment model in the United States violates these concepts of pluralism and patient choice by only allowing its recipients to use government funds for the payment and by limiting recipients to a single defined benefit and pharmacy package,

Whereas, These flaws in the Medicaid health care delivery system are contributing to the need for Medicaid Payment System reform, therefore be it

RESOLVED, That our American Medical Association support reform of the Medicaid health care delivery model using the principles of expanded individual choice, individual opportunity, individual and governmental responsibility (New HOD Policy); and be it further

RESOLVED, That our AMA support reform of the Medicaid healthcare delivery model which provides the individual patient the opportunity and responsibility to make wise choices in their own health care delivery model, and to share in the financial savings when using the Medicaid healthcare delivery system wisely (New HOD Policy); and be it further

RESOLVED, That our AMA encourage pluralism and patient choice in the Medicaid healthcare delivery model by requesting the Centers for Medicare and Medicaid Services develop multiple patient choice healthcare payment options at the Federal level, or by approving waivers at the state level, that include but are not limited to the following:

Option 1: Maintenance of the traditional legacy Medicaid program whereby the recipient is allotted a defined contribution per member per month and is provided a government issued identification card, which upon presentation entitles that recipient to receive healthcare services from any willing provider according to a defined benefit package and prescription formulary. Recipients desiring expanded healthcare services or pharmacy benefits may obtain this by paying the additional cost out-of-pocket.

Option 2: Creation of a Medicaid Advantage program similar to a Medicare Advantage program where the defined Medicaid contribution for the recipient is assigned to a third party which in turn must provide the health care services to the recipient. This third party then utilizes the principles of managed care to generate savings which can then be applied to the recipient in the form of expanded services and pharmacy benefits.

Option 3: Creation of a Medicaid voucher system whereby the recipient could then apply that Medicaid defined contribution toward the purchase of private healthcare coverage of their choice. The recipient could choose a coverage plan similar to the defined benefit package of traditional Medicaid, and if they could find such coverage for a lower premium the recipient could apply the savings toward the purchase of expanded service or pharmacy benefit. The premium for that basic benefit packaged could be required by insurance rule never to be more than the defined contribution amount provided by Medicaid. This protects the recipient from excess personal expense. The recipient could also choose to contribute employer sponsored health care plan premium funds, personal funds, or other funds such as those provided by a philanthropic organization to expand the premium and thus choose to enhance the healthcare or pharmacy benefit.

Option 4: Creation of a Medicaid Medical Savings Account program in which the Medicaid defined contribution allotted for each recipient is then assigned to an account created for the recipient. The recipient can then choose the health care delivery model best for them, with the cost then assigned to that model. Healthcare coverage is maintained for wellness care, illness care and accident care by participation in in a health system payment model, but the recipient is incentivized to maintain healthy lifestyle and judiciously use the healthcare delivery system by sharing in any savings they help to create. These savings can then be used contemporaneously to acquire expanded healthcare or pharmacy services, or be retained in that recipient account until such time as they reach the age of eligibility for Medicare. Those lifetime accumulated savings could then be used to purchase Medicare supplemental insurance coverage, or the savings could be transferred to the recipient’s Social Security or other retirement plan for any use in their retirement years. (New HOD Policy)

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

Received: 04/11/18

RELEVANT AMA POLICY

Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901 - Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when
appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation. Citation: Res. 815, I-16

**Health Insurance Exchange Authority and Operation H-165.839** - 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.

2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information. Citation: CMS Rep 3, I-09, Reaffirmation A-10, Reaffirmation in lieu of Res. 105, A-10, Appended: CMS Rep. 6, I-11, Reaffirmed in lieu of Res. 812, I-13, Reaffirmed: Sub Res. 813, I-13, Reaffirmed: Res. 108, A-17.

**Educating the American People About Health System Reform H-165.844** - Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. Citation: Res. 717, I-07, Reaffirmed: A-09

**State Efforts to Expand Coverage to the Uninsured H-165.845** - Our AMA supports the following principles to guide in the evaluation of state health system reform proposals: 1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level. 2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage. 3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable. 4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care. 5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations. Citation: CMS Rep. 3, I-07, Reaffirmed: Res. 239, A-12


**Expanding Choice in the Private Sector H-165.881** - Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee’s health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. Citation: BOT Rep. 23, A-97, Reaffirmed BOT Rep. 6, A-98, Reaffirmation A-02, Reaffirmed: CMS Rep. 4, A-12
Individual Health Insurance H-165.920 - Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will: (a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons; (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures; (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax (13) advocates that, upon replacement, with tax credits for individually purchased health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons; (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures; (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax (13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and (14) believes that refundable, advanced tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. (15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. Citation: BOT Rep. 41, I-93CMS Rep. 11, I-94Reaffirmed by Sub. Res. 125 and Sub. Res. 10 A-95 Amended by CMS Rep. 2, I-96 Amended and Reaffirmed by CMS Rep. 7, A-97 Reaffirmation A-97 Reaffirmed: CMS Rep. 5, I-97 Res. 212, I-97 Appended and Amended by CMS Rep. 9, A-98 Reaffirmation I-98 Reaffirmation I-98 Res. 105 & 108, A-99 Reaffirmation A-99 Reaffirmed: CMS Rep. 5 and 7, I-99 Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00 Reaffirmation I-00 Reaffirmed: CMS Rep. 2, I-01 Reaffirmed CMS Rep. 5, A-02 Reaffirmation A-03 Reaffirmed: CMS Rep. 1 and 3, A-02 Reaffirmed CMS Rep. 3, I-02 Reaffirmed: CMS Rep. 3, I-03 Reaffirmation I-03 Reaffirmation A-04 Consolidated: CMS Rep. 7, I-05 Modified: CMS Rep. 3, A-06 Reaffirmed in lieu of Res. 105, A-06 Reaffirmation A-07Appended and Modified: CMS Rep. 5, A-08 Modified: CMS Rep. 8, A-08 Reaffirmation A-10 Reaffirmed: CMS Rep. 9, A-11 Reaffirmation A-11Reaffirmed: Res. 239, A-12 Appended: Res. 239, A-12 Reaffirmed: CMS Rep. 6, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmed in lieu of: Res. 805, I-17

See also: Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982; Affordable Care Act Medicaid Expansion H-290.965; Medicaid Expansion Options and Alternatives H-290.986; Health Savings Accounts in the Medicaid Program H-290.972; Access to Care by Medicaid Patients H-290.999; Reform the Medicare System D-330.924; Patient Information and Choice H-373.993; Health Care Reform Physician Payment Models D-385.963; Freedom of Choice H-390.854; Informed Choice for Patients H-415.988; Moving to Alternative Payment Models H-450.931
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-18)

Introduced by: American Academy of Pediatrics

Subject: Effectiveness of Risk Assessment Models in Representing Healthcare Resources Expended for Infants and Children

Referred to: Reference Committee A
(Jonathan D. Leffert, MD, Chair)

Whereas, Risk adjustment models represent the foundation by which health insurance organizations and alternative payment models assess probability of resource utilization among patients; and

Whereas, Risk adjustment methodologies typically utilize a standard population representing a combination of adults and children whereby conditions of childhood may be under-represented and whereby calculated risk adjustment factors may not be reflective of resource utilization across all age groups; and

Whereas, Although the Hierarchal Condition Category models published as CMS-HCC (for Medicare Advantage) and as HHS-HCC (for non-Medicare use) provide structural detail including stratification of infant and child, healthcare organizations may modify HCC models in proprietary ways that are not transparently disclosed to providers; and

Whereas, Childhood-relevant, resource-intensive conditions often represent complex associations of chronic abnormalities (especially behavioral) exacerbated by unfavorable social health determinants all of which may be under-represented in proprietary risk adjustment models; therefore be it

RESOLVED, That our American Medical Association support risk modeling that appropriately represents care that is specific to all age groups including infants, children, and adolescents as unique risk strata (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that health insurance organizations transparently publish their risk adjustment models so that clinicians can more effectively document care that reflects patient risk and so that clinicians can assess whether the risk adjustment model appropriately defines the risk of their patients. (New HOD Policy)

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

Received: 04/19/18
References:


RELEVANT AMA POLICY


Hierarchical Condition Category Coding D-160.928 - Our AMA will continue to work with the Centers for Medicare and Medicaid Services to refine risk adjustment in all alternative payment models and Medicare Advantage plans, particularly to revise risk-adjustment processes, to allow hierarchical condition category (HCC) codes to automatically follow the beneficiary from year-to-year to reflect chronic conditions that will never change. Res. 112, A-16

Risk Adjustment Refinement in ACO Settings and Medicare Shared Savings Programs D-160.927 - Our AMA will continue seeking the even application of risk-adjustment in ACO settings to allow Hierarchical Condition Category risk scores to increase year-over-year within an agreement period for the continuously assigned Medicare Shared Savings Program beneficiaries and report progress back to this House at the 2017 Annual Meeting. Res. 114, A-16.
Whereas, Many national health leaders such as the HHS Secretary and the Surgeon General hail from Indiana, it may be instructive to observe Indiana health initiatives; and

Whereas, Indiana’s new Medicaid waiver includes a lock-out provision whereby eligibles who fail to promptly complete the state’s periodic eligibility redetermination can no longer simply reapply for benefits and instead remain ‘locked out’ for three months; and

Whereas, Indiana officials estimate half of people who fail to satisfy the redetermination process remain eligible; and

Whereas, This rule forces people to do without coverage for missing a paperwork deadline; and

Whereas, This rule will result in discontinuation of health care delivery for thousands of our most vulnerable citizens including children and the elderly; therefore be it

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

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

Received: 04/25/18

RELEVANT AMA POLICY

Medicaid - Towards Reforming the Program H-290.997
Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles:
(1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors);
(2) the creation of basic national standards of uniform minimum adequate benefits;
(3) the elimination of the existing categorical requirements;
(4) the creation of adequate payment levels to assure broad access to care; and
(5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions.
Whereas, The Affordable Care Act provided that if a patient had an emergency hospital admission and was treated by an out of network physician, that the insurer could hold the patient responsible for no more than they would have for an in-network doctor, which seemed to suggest that the insurer would be paying the physician's bill; and

Whereas, The subsequent Health and Human Service regulation on this provision said that in this case, the insurer need pay only the greater of three sums (1) Medicare; (2) the insurer’s in-network rate; or (3) the insurer’s out-of-network rate; and

Whereas, National medical organizations strongly objected at the time that this would leave the determination of the out of network payment entirely up to the insurer; and

Whereas, Most insurers have subsequently changed their out of network rate to a percentage of Medicare, and are therefore not required to pay more than a very small portion of emergency out of network physician bills, leaving patients to pay the majority of the bills; and

Whereas, The HHS regulation further stipulated that the health insurer’s requirement not to hold the patient responsible for more than a small fixed out of pocket yearly maximum did not apply in this case, again freeing the insurer from paying for the physician’s services; and

Whereas, One of the basic provisions of a health insurance plan should be that major emergency bills are covered; and

Whereas, For many physicians, the ability to get paid for emergency work is an important component of their ability to maintain a viable practice; and

Whereas, A new HHS administration might well be willing to reverse a flawed regulation of a prior administration; therefore be it

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

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

Out-of-Network Care D-285.962
Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care.
Res. 108, A-17

Out-of-Network Care H-285.904
Our AMA adopts the following principles related to unanticipated out-of-network care:
1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
7. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
8. Mediation should be permitted in those instances where a physicians unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.
Res. 108, A-17

See also: Network Adequacy H-285.908
Whereas, Negative payment decisions have and are being made related to the use of high molecular weight hyaluronic acid (HMWHA) based partially upon the American Academy of Orthopedic Surgeon’s (AAOS) Clinical Practice Guidelines (CPG) and Appropriate Use Criteria (AUC) on knee osteoarthritis published in 2013¹; and

Whereas, The AAOS Clinical Practice Guidelines recommended that payment decisions should not be based upon its opinion for the usage of hyaluronic acid; and

Whereas, Conclusions drawn from recent reviews of studies indicate one of the most efficacious treatment modalities for knee osteoarthritis is hyaluronic acid²; therefore be it

RESOLVED, That our American Medical Association advocate for reimbursement and national coverage for high molecular weight hyaluronic acid intraarticular injections as appropriate care and treatment for patients with mild to moderate osteoarthritis of the knee. (New HOD Policy)

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

Received: 04/25/18

¹ 2013 AAOS Clinical Practice Guidelines: TREATMENT OF OSTEOARTHRITIS OF THE KNEE
² AANA Nov. 13, 2017 letter to Anthem Re: Evidence supporting the value of high molecular weight hyaluronic acid for the care and treatment for patients with mild to moderate osteoarthritis of the knee.
Whereas, Health care cost has continued to rise and payers are devising plans to decrease health care expenditure; and

Whereas, Government and commercial payers are shifting inpatient care to outpatient settings; and

Whereas, Government and commercial payers discourage patient utilization of hospital emergency rooms; and

Whereas, Patients cannot determine, before appropriate medical evaluation, the need to be under emergency care; and

Whereas, Many states including Georgia, Kentucky, Indiana, and Missouri have implemented requirements on publicly sponsored health plan policies to increase insured/enrollee cost sharing for “non-urgent” care provided in the emergency room; and

Whereas, Anthem has included policy language in some insurance markets which deny coverage for “non-urgent” care provided in the emergency room; and

Whereas, Patients cannot self-diagnose prior to appropriate emergency room evaluation; and

Whereas, Patients are left with increasing cost sharing and in some instances the entire emergency room bill when the condition is retrospectively determined to be “non-urgent”; therefore be it

RESOLVED, That our American Medical Association actively work toward ensuring strong enforcement of federal and state laws which require health insurance companies to cover emergency room care when a patient reasonably believes they are in need of immediate medical attention, including the imposition of meaningful financial penalties on insurers who do not comply with the law. (Directive to Take Action)

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

Received: 04/25/18
RELEVANT AMA POLICY

Billing Procedures for Emergency Care H-130.978
(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.

Access to Emergency Services H-130.970
1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.
(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)
(C) All health plans should be prohibited from requiring prior authorization for emergency services.
(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.
(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.
(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not.
(G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.
(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.
(I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.
2. Our AMA will 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.

Introduced by: New York

Subject: Opposition to Medicaid Work Requirement

Referred to: Reference Committee A
(Jonathan D. Leffert, MD, Chair)

Whereas, In recent years many states have expanded Medicaid eligibility; and

Whereas, Medicaid expansion has helped lower the uninsured rate; and

Whereas, The federal government has recently given states permission to obtain a waiver in order to impose work requirements on Medicaid beneficiaries; and

Whereas, Most non-elderly Medicaid adults already are working or face significant barriers to work; and

Whereas, It is unclear if tying eligibility to work promotes health or is instead an indicator of health; and

Whereas, Working at minimum wage may paradoxically render some people ineligible for Medicaid; and

Whereas, Tens of thousands of eligible people may lose coverage simply for failing to adequately document their eligibility; and

Whereas, Work requirements may support the goals of cash programs (such as welfare), it may be antithetical to the goals of health coverage programs; therefore be it

RESOLVED, That our American Medical Association reaffirm policy H-290.961 which opposes work requirements as a criterion for Medicaid eligibility. (Reaffirm HOD Policy)

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

Received: 04/25/18

RELEVANT AMA POLICY

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility.
Res. 802, I-17
WHEREAS, Current AMA Policy H-165.847 establishes that comprehensive health system reform achieving quality healthcare for all Americans is of the highest priority to our AMA; and

WHEREAS, Our AMA is limited in its ability to engage in open and honest debate about all health care reform options via its blanket opposition to single payer financing mechanisms (AMA Policy H-165.838); and

WHEREAS, Evidence suggests that our AMA’s stance on single payer does not currently represent the majority of physicians, with two recent surveys by the Merritt Hawkins and the Chicago Medical Society each reporting a majority of physicians either strongly or somewhat supporting the concept of a broadly labeled single payer health care system;1,2 and

WHEREAS, Several US senators have recently supported legislation to move forward with a national single-payer health care financing reform, and as such our AMA must be equipped to have open, productive discussions on the matter in the coming years;3 and

WHEREAS, H.R. 676 - Expanded & Improved Medicare For All Act - has 122 cosponsors, and as such will likely come to the AMA for debate in the near future,4 therefore be it

RESOLVED, That our AMA rescind HOD Policy H-165.844; and be it further

RESOLVED, That our AMA rescind HOD Policy H-165.985; and be it further

RESOLVED, That our AMA amend HOD Policy H-165.888 by deletion as follows:

Evaluating Health System Reform Proposals
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
   A. Physician’s maintain primary ethical responsibility to advocate for their patients’ interests and needs.

---

B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend HOD policy H-165.838 by deletion as follows:

Health System Reform Legislation

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

a. Health insurance coverage for all Americans

b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps

c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
1. Investments and incentives for quality improvement and prevention and wellness initiatives
2. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
3. Implementation of medical liability reforms to reduce the cost of defensive medicine
4. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
5. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
6. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
7. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
8. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
9. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
10. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
11. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
   a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
   b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
   c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
   d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
   e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
   f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
12. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
13. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a “call to action” with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (Modify Current HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 04/26/18

Relevant AMA Policy:

Achieving Health Care Coverage for All D-165.974
Achieving Health Care Coverage for All -- Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy.
Citation: (Res. 733, I-02; Modified: CCB/CLRDP Rep. 4, A-12)

Educating the American People About Health System Reform H-165.844
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.
Citation: (Res. 717, I-07; Reaffirmation A-09)

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Citation: (Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12)

See also: Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care D-165.935; Individual Health Insurance H-165.920; Preferred Provider Organizations H-415.999; Reform the Medicare System D-330.924; Increasing Detection of Mental Illness and Encouraging Education D-345.994; Health System Reform Legislation H-165.838; Opposition to Nationalized Health Care H-165.985; Evaluating Health System Reform Proposals H-165.888
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-18)

Introduced by: Medical Student Section

Subject: Medicaid Coverage of Fitness Facility Memberships

Referred to: Reference Committee A
(Jonathan D. Leffert, MD, Chair)

Whereas, Low-income adults who qualify for Medicaid bear the greatest burden of chronic diseases, including diabetes mellitus, cardiovascular disease, and obesity;¹ and

Whereas, Forty-two percent of Americans today live with multiple chronic conditions, constituting over 70 percent of all healthcare spending in the United States;²,³,⁴,⁵,⁶ and

Whereas, For every dollar spent on Medicaid, 83 cents go towards the treatment of chronic diseases;⁵,⁷ and

Whereas, The frequency of fitness center visits has been shown to be directly correlated with monthly healthcare savings;⁶,⁸ and

Whereas, In contrast to private fitness facilities, community-based recreational exercise spaces are often pedestrian-unfriendly, unsafe, or inaccessible, leading to their underutilization;⁷,⁹ and

Whereas, Cost is a major barrier to attaining fitness facility memberships, particularly for families eligible for Medicaid;⁶,⁹,¹⁰,¹¹ and

Whereas, In a survey of low-income adults at risk for chronic disease, fitness facility memberships were rated as the most helpful among insurance-provided wellness benefits;¹⁰ and

Whereas, Fitness facility memberships alone yielded similarly effective improvements in chronic illness-related risk factors, in comparison to more costly comprehensive wellness programs that added nutritional education and personal fitness trainers;¹¹ and

Whereas, Existing AMA policies urge the development of exercise programs targeted to individuals over 65 and under 18, but non-elderly adults living in poverty have limited access to basic fitness facilities (AMA Policies H-25.995, H-470.961, H-470.975, H-470.989, H-470.998, H-470.999); and

Whereas, Existing AMA policies call upon physicians to promote physical fitness to the general public and encourage funding of community exercise venues in order to reduce incidence of chronic illness (H-470.990, H-470.991, H-470.997, D-470.993); therefore be it

RESOLVED, That our American Medical Association support Medicaid coverage of fitness facility memberships as a standard preventive health insurance benefit for patients. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Promotion of Exercise H-470.991
1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.
2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.
Citation: (Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRDP Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11)

Government to Support Community Exercise Venues D-470.993
Our AMA will encourage: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities.
Citation: (Res. 423, A-04; Reaffirmed in lieu of Res. 434, A-12)

Requirement for Daily Free Play in Schools H-470.961
Our AMA recommends that elementary schools maintain at least thirty minutes of daily free play or physical education that is consistent with CDC guidelines.
Citation: Res. 409, A-04; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17; Cardiovascular Preparticipation Screening of Student Athletes H-470.962
Our AMA supports increasing awareness among physicians, state and local medical societies, parent-teacher organizations, state legislatures, athletic associations, school administrators, and school boards of the availability of consensus medical guidelines and recommendations for sports preparticipation evaluations
Citation: (CSA Rep. 5, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09)

See also: Mandatory Physical Education H-470.975; Physical Fitness and Physical Education H-470.989; Youth Physical Fitness H-470.998; Youth Fitness H-470.999; Promotion of Exercise Within Medicine and Society H-470.990; Exercise Programs for the Elderly H-25.995; Exercise and Physical Fitness H-470.997

Introduced by: Missouri

Subject: Return to Prudent Layperson Standard for Emergency Services

Referred to: Reference Committee A
(Jonathan D. Leffert, MD, Chair)

Whereas, Symptomatic patients cannot accurately determine the need for emergency medical care prospectively; and

Whereas, The Emergency Medicine Treatment and Active Labor Act of 1986 (EMTALA) established a mandate for the provision of emergency medical care, the violation of which jeopardizes the very existence and continuance of hospital operations; and

Whereas, The federal program of Medicare and the federally sponsored program of Medicaid adopted a prudent layperson standard for seeking emergency medical care as incorporated in the Balanced Budget Act of 1997; and

Whereas, Many states have adopted a prudent layperson standard for seeking emergency medical care; and

Whereas, Anthem Blue Cross and Blue Shield has adopted a list of diagnoses that the insurer will not pay for, an ex post facto action that does not consider the prudent layperson standard or the necessary work of emergency department physicians to make the diagnosis; therefore be it

RESOLVED, That our American Medical Association oppose the arbitrary denial of payment for emergency services based on diagnostic coding alone and support the use of the prudent layperson standard. (New HOD Policy)

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

Received: 04/30/18
RELEVANT AMA POLICY

Access to Emergency Services H-130.970
1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.
(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

Coverage of Emergency Services D-130.989
Our AMA: (1) will promote legislation, regulation, or both to require all health payers to utilize the AMA's definition of "emergency medical condition"; (2) will promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy; and (3) in conjunction with interested national medical specialty societies, continue to work expeditiously toward a comprehensive legislative solution to the continued expansion of EMTALA and problems under its current rules.
Citation: (Res. 229, A-01; Reaffirmed: BOT Rep. 22, A-11)
Whereas, Periodontal disease is closely linked to coronary heart disease, endocarditis, and hypertension; and

Whereas, Cardiovascular disease is the leading cause of death and disability in Medicare recipients; and

Whereas, Oral health is integral to an individual's overall health and well-being; and

Whereas, Prevention and treatment is effective in reducing adverse consequences of dental disease; and

Whereas, Current AMA policy recognizes the importance of access to comprehensive dental services as part of optimal patient (D-160.925), and supports provision of dental care insurance for medical students, residents and fellows in training (H-295.873 and H-310.912), and persons with developmental disabilities (H-90.968); and

Whereas, The Medicare program established by Congress in 1965 to provide Americans age 65 and over with insurance for hospital and physician services "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member," explicitly omitting coverage for prevention and screening of disease and most dental services, and chronic care of patients of all ages with end-stage renal disease; and

Whereas, Congress has amended original Medicare to include several preventive services, including screening for breast cancer, colorectal cancer and abdominal aortic aneurysm; and

Whereas, Value-based healthcare is evolving to prevent acute illness and treat chronic diseases outside the hospital; and

Whereas, Dental offices and clinics are an important component in effective healthcare delivery; therefore be it

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

RESOLVED, That our AMA promote and support legislative and administrative action to include preventive and therapeutic dental services as a standard benefit for all Medicare recipients. (Directive to Take Action)
Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/18

RELEVANT AMA POLICY

Importance of Oral Health in Patient Care D-160.925
Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.
Citation: Res. 911, I-16

Eliminating Benefits Waiting Periods for Residents and Fellows H-295.873
Our AMA:
(1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training;
(2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees’ first date of employment and to aggressively enforce this requirement; and
(3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education.
(4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees.
Citation: (BOT Action in response to referred for decision Res. 318, A-06; Appended: CME Rep. 5, A-10)

See also: Residents and Fellows' Bill of Rights H-310.912
Medical Care of Persons with Developmental Disabilities H-90.968
Whereas, Medicare beneficiaries who need skilled nursing care in a nursing facility are required to have an inpatient stay in a hospital lasting for three midnights at a minimum before they are eligible for such care; and

Whereas, Even as skilled nursing care is expensive, such care is essential to maintain wellness and wellbeing of our aging population, especially after bouts of acute illness; and

Whereas, Programs that participate in a downside risk sharing arrangement with Medicare—such as a Track 1+ or higher Accountable Care Organizations (ACO) or the Advanced Bundled Payments for Care Improvement Programs - have an inherent incentive to be good stewards of the Medicare program and generate savings for the Government; and

Whereas, Some Medicare ACOs (Track 1+ and above) are allowed to waive three midnight stay requirements, the process is not uniform, nor is it Physician centric; therefore be it

RESOLVED, That our American Medical Association support provisions that allow attending physicians caring for Medicare recipients in any setting be allowed to waive the three midnight inpatient stay requirement for initiation of skilled nursing care in a facility when the attending physician and the skilled nursing facility are both part of a downside risk sharing arrangement with Medicare--such as a Track 1+ or higher Medicare Accountable Care Organization or an Advanced Bundled Payments for Care Improvement Program. (New HOD Policy)

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

Received: 05/01/18
WHEREAS, According to the Office of Cancer Survivorship at the National Cancer Institute, in
2016 there were an estimated 15.5 million cancer survivors in the United States, projected to
increase to 20.3 million by 2026 and 26.1 million by 2040; and

WHEREAS, In 2006 the Institute of Medicine (IOM) issued a report recommending every cancer
patient receive an individualized survivorship care plan (SCP) that includes guidelines for
monitoring and maintaining their health, yet a recent Commission on Cancer (CoC) survey of
accredited programs found that just 21% indicated that a survivorship care plan process had
been developed; and

WHEREAS, Major barriers to SCP implementation include (1) lack of diagnostic codes [i.e. the
ICD-10 code for ‘cancer survivorship’ is Z85, an aftercare code indicating ‘personal history of
malignant neoplasm’ that is not directly billable]; (2) no care protocols compatible with electronic
health record (EHR) templates; and (3) absence of specific evaluation and management (E&M)
codes despite the high complexity of care and medical-decision making [MDM] associated with
SCPs; and

WHEREAS, Codifying survivorship as a distinct clinical category that belongs on problem lists with
payment-linked (fee, value based, or capitated) care services benefits healthcare delivery
across specialties, and moreover meets the needs of a growing cadre of patients; therefore be it
RESOLVED, That our American Medical Association study challenges in billing and coding for
cancer survivorship care and invite collaboration from internal medicine and specialty societies
for guideline development and implementation (Directive to Take Action); and be it further
RESOLVED, That our AMA prioritize assignation of distinct ICD-10 and E&M codes associated
with cancer survivorship care, and collaborate with the Centers for Medicare and Medicaid
Services implementation in order to provide standards of care and reimbursement for
survivorship care plans. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/02/18

Whereas, The Centers for Medicare and Medicaid Services (CMS) had allowed bundled payments for certain diagnoses under the Bundled Payment for Care Initiative (BCPI) program to be initiated by the start of Skilled Nursing Facility (SNF) stay and 90 days beyond (Model 3 Post-Acute only - BPCI); and

Whereas, CMS and numerous participating SNFs have generated savings and created efficiencies and better outcomes in post-acute care of Medicare recipients by way of BPCI Model 3; and

Whereas, In the ‘BPCI- Advanced’ version, initiation of bundles in SNFs has been left out, thereby excluding SNFs and physicians working in SNF setting from initiating bundles; therefore be it

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

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

Received: 05/01/18
Reference Committee B

BOT Report(s)

09 Council on Legislation Sunset Review of 2008 House Policies
12 Advocacy for Seamless Interface Between Physician Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs
14 Integration of Drug Price Information into Electronic Medical Records / Barriers to Price Transparency / Bidirectional Communication for EHR Software and Pharmacies / Health Plan, Pharmacy, Electronic Health Records Integration
15 Advanced Practice Registered Nurse Compact
16 Protection of Clinician-Patient Privilege
17 Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care
18 Medical Liability Coverage Through the Federal Tort Claims Act
19 Health Information Technology Principles
41 Augmented Intelligence in Health Care

Resolution(s)

201 Removing Barriers to Obesity Treatment
202 Universal and Standardized Protocols for EHR Data Transition
203 Updating Federal Food Policy to Improve Nutrition and Health
204 Opposition to Mandated Proficiency in EHR for Licensure
205 Augmented Intelligence
206 Appropriate Use of Telehealth Services
207 Quality Improvement Requirements
208 Prior Authorization Requirements for Post-Operative Opioids
209 Substance Use Disorders During Pregnancy
210 Banning the Sale of Bump Stocks
211 Clarification from U.S. Department of Justice Regarding Federal Enforcement of Medical Marijuana Laws
212 Value-Based Payment System
213 Utilization Review
214 Strengthening the Background Check System for Firearm Sales
215 Regulation of Hospital Advertising
216 FDA Conflict of Interest
217 Reforming the Orphan Drug Act
218 Considering Feminine Hygiene Products as Medical Necessities
219 Improving Medicare Patients’ Access to Kidney Transplantation
220 Ban on Semi-Automatic Assault Weapons and High Capacity Ammunition Magazines
221 Maintaining Validity and Comprehensiveness of U.S. Census Data
222 Evidence Based Treatment in Substance Abuse Treatment Facilities
223 Treating Opioid Use Disorder in Hospitals
224 Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions
225 Pharmacy Benefit Managers Impact on Patients
226 Model State Legislation for Routine Preventative Prostate Cancer Screening for Men Ages 55-69
227 An Optional National Prescription Drug Formulary
228 Medicare Quality Incentives
229 Green Card Backlog for Immigrant Doctors on H-1B Visa
230 Opposition to Funding Cuts for Programs that Impact the Health of Populations
Reference Committee B

Resolution(s)

231  Online Controlled Drugs
232  Recording Law Reform
233  Support for Reauthorization of the Supplemental Nutrition Assistance Program
234  Support for Primary Care Enhancement Act
235  Hospital Consolidation
236  Reducing MIPS Reporting Burden
237  Safe and Efficient E-Prescribing
238  Reform of Pharmaceutical Pricing: Negotiated Payment Schedules
239  Treating Opioid Use Disorder in Hospitals
240  Treating Opioid Use Disorder in Treatment Facilities
241  Accuracy and Accountability of Physician Compensation Reporting by Drug and Device Companies
242  Pharmacy Benefit Managers and Compounded Medications
243  Report Health Care Provider Sex Crimes to Law Enforcement
REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-A-18

Subject: Council on Legislation Sunset Review of 2008 House Policies

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

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

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

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

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

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

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

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.
## APPENDIX 1
### RECOMMENDED ACTIONS ON 2008 HOUSE POLICIES

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Text</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-180.972</td>
<td>Increased Third Party Payer Accountability</td>
<td>The AMA will include in its legislative and/or public relations programs the goal of putting an end to inflammatory language contained in third party payer notifications to patients. Citation: (Res. 235, A-92; Reaffirmed: Sub. Res. 106, I-98; Reaffirmation I-98; Reaffirmed: CLRDPD Rep. 1, A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-245.971</td>
<td>Home Deliveries</td>
<td>Our AMA: (1) supports the recent American College of Obstetricians and Gynecologists (ACOG) statement that “the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers”; and (2) supports state legislation that helps ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the AAP and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers. Citation: (Res. 205, A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-270.957</td>
<td>FTC Identification Theft Prevention Programs</td>
<td>Our AMA is commended for its efforts to eliminate physicians under the definition of ‘creditors’ as currently interpreted by the Federal Trade Commission (FTC) in its rules implementing the Fair and Accurate Credit Transaction Act of 2003, and will continue its vigorous advocacy opposing the FTC’s efforts to include physicians as creditors under the FACTA 2003. Citation: Res. 222, I-08</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-270.965</td>
<td>Physician-Assisted Suicide</td>
<td>Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer. Citation: (Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-315.977</td>
<td>Abuse of the Medical Record for Regulation or Financing the Practice of Medicine</td>
<td>(1) Our AMA continues to oppose the use of the physician office medical record as a tool of CMS, as well as any other agency or third party, to regulate the financing and practice of medicine. (2) The medical record shall be the property of the physician and the information contained therein, the property of the patient. (3) The physician’s office medical record should be used solely to document the delivery of health care. Citation: (Res. 820, A-99; Reaffirmation I-08)</td>
<td>Rescind — this policy is no longer relevant.</td>
</tr>
<tr>
<td>H-330.893</td>
<td>Medicare Election Period</td>
<td>AMA policy is that physicians should be given the option of a Medicare semi-annual participation election period occurring at the end and the middle of the calendar year. Our AMA will petition the Centers for Medicare &amp; Medicaid Services to permit a semi-annual participation election period occurring at the end and the middle of the calendar year. Citation: (Res. 216, I-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-335.963</td>
<td>Member Education on Medicare Recovery Audit Contractors</td>
<td>Our AMA: (1) will educate our membership about the effect of the program’s safeguard contractor activity and Recovery Audit Contractor (RAC) audits on individual physician practices, expansion of the RAC program, and assistance that may be available through our AMA; and (2) will actively support the legislation currently before Congress to require an immediate moratorium on the expansion of the RAC program, and will seek the introduction of subsequent legislation that would limit or exclude physician billings from the authority of RAC audits altogether. Citation: (Sub. Res. 226, A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>H-350.961</td>
<td>Improving the Health of Minority Populations</td>
<td>Our AMA urges Congress to re-evaluate and expand the federal race and ethnicity categories to include additional ethnic subgroups in order to analyze and uncover racial and ethnic health and healthcare disparities. Citation: (Res. 906, I-08)</td>
<td>Rescind — this policy is no longer relevant. The U.S. Department of Health and Human Services does include multiple ethnic subgroups with respect</td>
</tr>
<tr>
<td>H-360.998</td>
<td>Cardiac Resuscitation by Nurses</td>
<td>With the intent of promoting good patient care, the AMA recognizes the propriety of registered nurses using monitoring, defibrillation, and resuscitative equipment, and instituting immediate life-saving corrective measures, if a licensed physician is not immediately available to do so, providing that: (1) The techniques to be used by a registered nurse in a hospital setting shall have been specified for the hospital by the medical staff on the basis of counsel by a committee representing authoritative medical and nursing opinion; (2) The registered nurse has been competently instructed in the techniques to be used; and (3) The registered nurse performs the authorized procedures: (a) upon the direct order of a doctor of medicine, or (b) pursuant to standing procedures established by the medical staff, these procedures to include provision for immediate summoning of a physician and such other personnel as may be needed. Citation: (Res. 42, I-67; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>H-375.983</td>
<td>Appropriate Peer Review Procedures</td>
<td>(1) Our AMA urges state medical associations to investigate applicable state law to determine if additional state agency supervision of peer review is needed to meet the active state supervision requirement set forth by the Supreme Court. (2) Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity: (a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician’s medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought. The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization and the medical staff should each have separate legal counsel. The attorney of the body bringing the peer review action, be it the health care organization or the medical staff, should</td>
<td>Retain — policy remains relevant.</td>
</tr>
</tbody>
</table>
undertake the procedures needed to prepare for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. This health care organization or medical staff attorney should be instructed that his or her role includes assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The attorney for the body which is not bringing the peer review action should work to ensure that proper peer review processes as outlined in the medical staff bylaws are followed. The role of the attorney for the accused physician is solely to defend his or her client.

(b) The medical executive committee, through its attorney, may consult with the health care organization, through its attorney, regarding appointment of a hearing officer. If an attorney is sought to be the hearing officer, those solo attorneys or attorneys from a firm regularly used by the hospital, medical staff, or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities, should not be eligible to serve as hearing officers. The hearing officer shall gain no direct financial benefit from the outcome.

(c) The attorney advising the medical staff or, in the limited situation where the hospital is prosecuting the correction action, the attorney advising the health care organization, and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing officer.

(d) Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and at the discretion of the hearing officer.

(e) A court reporter should be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the court report shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it.

(f) Within the discretion of the hearing officer, witnesses may be requested to testify under oath.

(g) The role of the hearing panel should be defined in the medical staff bylaws. The role of
the hearing panel may include, without being limited to, such duties as: acting as an objective arbiter of evidence, examining witnesses, determining adherence to the standard of care, providing well-reasoned documented opinions and decisions, and other duties noted herein. The hearing panel should only consist of physicians, none of whom are direct economic competitors with the physician involved or who stand to gain through a recommendation or decision adverse to the physician. It is desirable that members of the hearing panel be physicians who have the respect of the medical community, and should include a fair representation of the same specialists/subspecialist physicians as the physician involved, whenever feasible.

(h) Physicians serving on the hearing panel should receive information and training in the elements and essentials of peer review. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. Wherever feasible, data collection and analysis, or similar assessment instruments, and multiple reviewers should be used to increase reliability in evaluating whether peer review disciplinary proceedings are warranted. Where feasible, statistical analysis to compare with peers’ performance must be used with appropriate case mix adjustments.

(i) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the health care organization, but a physician should not be deprived of his or her privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based.

(j) The hearing panel should credit the evidence brought before it in a manner reflective of the specificity of the evidence and the personal or economic biases of witnesses.

(k) When investigation is underway and indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a
<table>
<thead>
<tr>
<th>H-383.999</th>
<th><strong>Formation of a National Negotiating Organization</strong> for Physician Negotiation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs;</td>
</tr>
<tr>
<td></td>
<td>(2) Our AMA immediately implement a national labor organization under the National Labor Relations Act to support the development and operation of local negotiating units as an option for employed physicians;</td>
</tr>
<tr>
<td></td>
<td>(3) Our AMA immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to collectively bargain;</td>
</tr>
<tr>
<td></td>
<td>(42) Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and be prepared to implement a national labor organization to support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize labor organizations under the National Labor Relations Act;</td>
</tr>
<tr>
<td></td>
<td>(5) Our AMA continue to vigorously support antitrust relief for physicians and medical groups by actively supporting federal legislation consistent with the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304 introduced by Representative Tom Campbell, R-CA and John Conyers, D-MI), aggressively working with the Department of Justice and the Federal Trade Commission, and continue providing model legislation and information on the state-action doctrine to state medical associations and members;</td>
</tr>
<tr>
<td></td>
<td>(6) Our AMA be prepared to immediately Retain in part, with change in Title — some sections of this policy are no longer relevant or have been achieved or are addressed in other AMA policy.</td>
</tr>
</tbody>
</table>
implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups when the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304) become law; and

(7) Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers;

(8) That should the BOT determine that the Quality Health Care Coalition Act of 1999 (H. R. 1304) or similar legislation will not become law, our AMA immediately pursue the creation or adoption of new antitrust legislation to achieve the same goal; and

(9) Our AMA, concurrent to proceeding with the establishment of any collective bargaining unit, undertake an extensive education program, directed at its member and non-member physicians, as to the possible limits on benefits and the risks to the formation of such a unit.

Citation: (Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08)

<table>
<thead>
<tr>
<th>H-390.852</th>
<th>Legislative Action to End Medicare SGR Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Our AMA, working with our state and specialty society colleagues, will pursue enactment of legislation that provides for at least two years of positive updates that accurately reflect the increases in costs of caring for Medicare beneficiaries and lays the groundwork for complete repeal in the near future.</td>
<td></td>
</tr>
<tr>
<td>2. The AMA’s ultimate goal continues to be complete repeal of the SGR and its replacement with a fair and equitable payment system that adequately reflects increases in the cost of caring for Medicare beneficiaries.</td>
<td></td>
</tr>
<tr>
<td>Citation: (BOT Rep. 31, A-07; Reaffirmation I-08)</td>
<td></td>
</tr>
</tbody>
</table>

Rescind — The Medicare Access and CHIP Reauthorization Act of 2015 replaced the SGR with new payment updates for physicians.

<table>
<thead>
<tr>
<th>H-40.999</th>
<th>Medical Representation of Joint Chiefs of Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under supervision of qualified medical officers of the three military services, medical representation is essential to effect coordination of the medical and health aspects of tactical, strategic and long range planning in the Joint Staff, the Combined Staff and the Special Command Staffs.</td>
<td></td>
</tr>
</tbody>
</table>

Retain — policy remains relevant.
<p>| H-410.956 | Fairness and Quality in Medical Imaging Interpretation | Our AMA: (1) actively opposes efforts by federal and state legislators, regulatory bodies, private payers, public payers and radiology business management companies to preauthorize, precertify or otherwise restrict the application of advanced imaging services when such services are provided by qualified physicians in accordance with appropriateness guidelines, practice guidelines and technical standards for the imaging modalities utilized, as developed by specialty societies involved with the diagnosis and treatment of such patients; and (2) will actively work to ensure that all physician specialties involved in the care of patients with specific illnesses who need imaging services have equal participation and authority in the development of quality and efficiency measures for imaging services; and (3) will report back to the House of Delegates on an annual basis with details of actions AMA has taken to oppose efforts by private and public payers, radiology benefits managers and others to deny patients’ access to appropriate, high quality imaging services provided by qualified physicians regardless of their medical specialty. Citation: (Sub. Res. 208, A-08) | Retain — policy remains relevant. |
| H-410.957 | Intraoperative Neurophysiologic Monitoring | Our AMA policy is that supervision and interpretation of intraoperative neurophysiologic monitoring constitutes the practice of medicine, which can be delegated to non-physician personnel who are under the direct or online real time supervision of the operating surgeon or another physician trained in, or who has demonstrated competence in, neurophysiologic techniques and is available to interpret the studies and advise the surgeon during the surgical procedures. Citation: (Res. 201, A-08) | Retain — policy remains relevant. |
| H-420.958 | Surgical Sterilization and Family PACT Eligibility | Our AMA supports a change in the Family Planning, Access, Care and Treatment (Family PACT) legislation, and the appropriate funding necessary, such that surgical sterilization shall not be a reason for exclusion from the Family PACT program. Citation: (Res. 210, A-08) | Retain — policy remains relevant. |
| H-435.948 | Equality of Civil Liability Preemption for Physicians | Our AMA supports (1) efforts to grant physicians at least the same level of protection as manufacturers, whether by court decision or statute; and (2) state and federal legislation that addresses the civil liability of physicians who use FDA-approved devices and pharmaceuticals in a reasonable and prudent manner, so that physicians have at least the same level of protection offered the manufacturer for adverse events resulting from the use of said products. Citation: (Res. 201, I-08) | Retain — policy remains relevant. |
| H-435.950 | Apologizing to Patients | AMA policy is that any statements by physicians of apology, confessions of regret, or admission of errors to patients and/or their families regarding less than anticipated clinical outcomes be subsequently inadmissible in court, and will seek to incorporate such policy into medical liability reform legislation. Citation: (Res. 217, A-07; Reaffirmation A-08) | Retain — policy remains relevant. |
| H-435.993 | Tort Liability Reform | Our AMA: (1) supports the efforts of state medical societies to form coalitions supporting tort reform in each state and representing the numerous interests adversely affected by present escalating tort liability costs; and (2) believes these coalitions should address such issues as reform of laws governing product and professional liability, and development of appropriate public education programs regarding the impact and cost to consumers of present liability laws. Citation: (Sub. Res. 6, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmation A-00; Reaffirmation I-08) | Retain — policy remains relevant. |
| H-440.863 | Restoring the Independence of the Office of the US Surgeon General | Our AMA: (1) recognizes the Office of the United States Surgeon General as the esteemed position of the “nation’s doctor;” and (2) calls for the Office of the United States Surgeon General to be free from the undue influence of politics, and be guided by science and the integrity of his/her role as a physician in fulfilling the highest calling to promote the health and welfare of all people. Citation: Sub. Res. 434; A-08 | Retain — policy remains relevant. |
| H-510.989 | Health Care for Veterans and Their Families | Our AMA supports the recommendations of the President’s Commission on Care for America’s Wounded Warriors report “Serve, Support, | Retain — policy remains relevant. |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Category</th>
<th>Resolution</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-70.951</td>
<td>Medical Necessity Coding</td>
<td>(1) The AMA (a) immediately seeks both legislative and judicial relief from ICD-9 to ICD-10 coding requirements for reimbursement of medical and laboratory services; and (b) supports only medical record review for medical necessity determinations, and then only when inappropriate or illegal behavior is suspected. (2) That until full implementation of this policy is achieved, our AMA seeks regulatory relief that would give physicians flexibility in assigning ICD-9 to ICD-10 codes. (3) Our AMA advocates to all those private payers who do require ICD-9 to ICD-10 codes for diagnostic studies that physicians should have the flexibility to assign any clinically appropriate diagnosis code.</td>
<td>Retain, but update ICD-9 to ICD-10 — policy remains relevant.</td>
</tr>
<tr>
<td>D-160.946</td>
<td>Eliminating the Barriers to Surviving Acute Myocardial Infarction</td>
<td>Our AMA will: (1) work with relevant societies to conduct a thorough analysis of the geographic, economic and political barriers to optimal care for the ST-elevation myocardial infarction (STEMI) patient, e.g., the current environment, existing literature, the costs of ambulance ECG hardware, training and transmission; political issues of reimbursing one county for care provided to patients from another county or state, and the financial issues of shifting patients to centers that can perform preferred treatment algorithms; and (2) develop model legislation that would draw upon the successes of existing programs and the data garnered from a comprehensive environmental analysis, to identify workable solutions to breaking down the geographic, economic and political barriers to optimal care for the STEMI patient that currently exist.</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>D-165.946</td>
<td>Presidential Candidates’ Views on Health System Reform</td>
<td>Our AMA will use its communications vehicles such as the AMA website, to publicize the health care positions of the major US Presidential candidates and encourage physicians to become more informed voters.</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>D-190.976</td>
<td>Internet Submissions of Medicare Claims</td>
<td>Our AMA: (1) will develop principles describing appropriate use of the Internet in submitting Medicare claims; and (2) supports the use of high speed Internet as a mechanism to file Medicare claims with appropriate safeguards that adhere to federal law and HIPAA standards to ensure the protection of patient health information. Citation: (Res. 836, I-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>D-330.925</td>
<td>Medicare Enrollment and Re-enrollment Delays</td>
<td>Our AMA will seek legislation mandating that the Centers for Medicare &amp; Medicaid Services impose a requirement on its carriers and Medicare administrative contractors (MACs) that enrollment and re-enrollment applications must be processed within thirty days of receipt with appropriate feedback to the applicant, and that financial penalties be imposed on carriers and MACs for unjustified delays in enrollment and re-enrollment. Citation: (Res. 205, I-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>D-330.927</td>
<td>Medicare Advantage Program Budget Reduction</td>
<td>Our AMA will express our grave concerns to President Bush, the Executive Branch and Congress that a veto of legislation concerning a budget reduction in the Medicare Advantage Program with a corresponding increase in the Medicare Physician Fee Schedule would be an egregious error. Citation: (Res. 236, A-08)</td>
<td>Rescind — The Bush Administration is no longer in a position to veto this legislation, nor is it a current issue in Congress.</td>
</tr>
<tr>
<td>D-335.988</td>
<td>Audit Equity</td>
<td>Our AMA will seek relief from insurance inequity through legislation which instructs insurers to balance or refund for under-coding against any discovered over-coding during the course of an audit and not through extrapolation. Citation: (Res. 817, I-03; Reaffirmation A-08)</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>D-35.989</td>
<td>Midwifery Scope of Practice and Licensure</td>
<td>Our AMA will: (1) only advocate in legislative and regulatory arenas for the licensing of midwives who are certified by the American College of Nurse-Midwives; (2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards; (3) continue to monitor state legislative activities regarding the licensure and scope of practice of midwives; and (4) work with state medical societies and</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>Bill</td>
<td>Title</td>
<td>Description</td>
<td>Citation</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td>D-370.987</td>
<td>Study Incentives for Cadaveric Organ Donation</td>
<td>Our AMA will place high on its legislative agenda modification of the National Organ Transplantation Act to rescind prohibition of “valuable consideration” for cadaveric organ donation, so that pilot studies of financial incentives for donation can be carried out. Citation: (Res. 10, A-08)</td>
<td>Rescind — This policy has been superseded by H-370.958, Removing Disincentives and Studying The Use Of Incentives To Increase The National Organ Donor Pool.</td>
</tr>
<tr>
<td>D-383.989</td>
<td>Physician Freedom to Collectively Negotiate with Managed Care Plans and Health Insuring Organizations</td>
<td>Our AMA will: (1) increase the visibility of its campaign for antitrust relief for physicians, including specific strategies for accomplishing this goal; (2) prepare and distribute to its membership educational materials pertaining to current antitrust issues as it affects its members; (3) empower its members through these educational materials to embark upon a grassroots legislative campaign to secure antitrust relief for physicians when negotiating with third party payers; (4) speak forcefully to its membership that no member should feel compelled to sign any contractual agreement that harms his/her ability to provide compassionate and quality care to his/her patients; and (5) advance as part of its patient advocacy campaign that physicians must have the right to enter into group discussions with managed care companies, exempt from antitrust violations, for the purpose of reducing the barriers to patient access and administrative burdens on physicians that delay patient care even if prohibited, by law, from discussing fees and reimbursement rates. Citation: (Sub. Res. 229, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-08)</td>
<td>Retain—policy remains relevant.</td>
</tr>
<tr>
<td>D-383.990</td>
<td>AMA’s Aggressive Pursuit of Antitrust Reform</td>
<td>Our AMA will: (1) place a high priority on the level of support provided to AMA’s Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws; (2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between</td>
<td>Retain — policy remains relevant.</td>
</tr>
<tr>
<td>Section</td>
<td>Text</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B of T Rep. 9-A-18 -- page 14 of 17</td>
<td>physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the “state action doctrine”; (3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers; (4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means; (5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and (6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans. Citation: (Res. 908, I-03; Reaffirmation, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D-385.980</td>
<td>Provision of Payment Schedules and Methodology of Payment as Part of the Contracting Process</td>
<td>State medical associations that wish to pursue a ruling for their individual members similar to that used by the Medical Association of Georgia in obtaining relief from payment contract practices which do not disclose the full term of reimbursement should contact the Litigation Center for support. Our AMA, within its resources, should continue to assist physicians and medical associations that pursue well-grounded legal actions to secure disclosure from MCOs of their fee schedules and payment methodologies. Citation: (BOT Rep. 13, A-03; Reaffirmation A-08)</td>
<td></td>
</tr>
<tr>
<td>D-390.969</td>
<td>Parity in Medicare Reimbursement</td>
<td>Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the Medicare physician payment formula, the sustainable growth rate (SGR); (21) repeal or delay the reductions in Medicare payment for imaging services furnished in physicians’ offices, as mandated by the Deficit Reduction Act of 2005; (32) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in part — The Medicare Access and CHIP Reauthorization Act of 2015 replaced the sustainable growth rate system with new payment updates, and the payment reductions from the Deficit Reduction Act have Retain — policy remains relevant.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Action</td>
<td>Details</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D-410.996</td>
<td>Physician Seeking Regulation of Physicians</td>
<td>Retain</td>
<td>Policy remains relevant.</td>
</tr>
<tr>
<td>D-435.975</td>
<td>Blood Centers and Medical Liability</td>
<td>Retain</td>
<td>Policy remains relevant.</td>
</tr>
<tr>
<td>D-95.983</td>
<td>Mandatory Drug Screening Reporting</td>
<td>Retain</td>
<td>Policy remains relevant, but modify terms “positive” to “aberrant” and “drug screen” to “drug testing” and “drug tests” to reflect updated use of terms in this field. The original policy was written before drug monitoring was commonplace.</td>
</tr>
</tbody>
</table>

in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (43) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing.

Citation: (BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-08)
APPENDIX 2

AMA Policies Superseding Policies Recommended for Rescission

Policy H-383.999, Formation of a National Negotiating Organization “Physician Negotiation”
(1) All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs;
(2) Our AMA immediately implement a national labor organization under the National Labor Relations Act to support the development and operation of local negotiating units as an option for employed physicians;
(3) Our AMA immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to collectively bargain;
(4) Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and be prepared to implement a national labor organization to support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize labor organizations under the National Labor Relations Act;
(5) Our AMA continue to vigorously support antitrust relief for physicians and medical groups by actively supporting federal legislation consistent with the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304 introduced by Representative Tom Campbell, R-CA and John Conyers, D-MI), aggressively working with the Department of Justice and the Federal Trade Commission, and continue providing model legislation and information on the state action doctrine to state medical associations and members;
(6) Our AMA be prepared to immediately implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups when the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304) become law; and
(7) Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers;
(8) That should the BOT determine that the Quality Health Care Coalition Act of 1999 (H. R. 1304) or similar legislation will not become law, our AMA immediately pursue the creation or adoption of new antitrust legislation to achieve the same goal; and
(9) Our AMA, concurrent to proceeding with the establishment of any collective bargaining unit, undertake an extensive education program, directed at its member and non-member physicians, as to the possible limits on benefits and the risks to the formation of such a unit.

Citation: (Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08)

Policy D-383.990, “AMA’s Aggressive Pursuit of Antitrust Reform”
Our AMA will: (1) place a high priority on the level of support provided to AMA’s Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;
(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the “state action doctrine”;
(3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers;
(4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means;
(5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and
(6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans. Res. 908, I-03 Reaffirmation, A-05 Reaffirmed: BOT Rep. 10, I-05 Reaffirmation A-06 Reaffirmation A-08

Policy H-385.973, “Collective Negotiations”
It is the policy of the AMA to seek amendments to the National Labor Relations Act and other appropriate federal antitrust laws to allow physicians to negotiate collectively with payers who have market power. Res. 95, A-90 Reaffirmed by BOT Rep. 33, A-96 Reaffirmation A-97 Reaffirmation I-98 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation A-01 Reaffirmation A-04 Reaffirmation A-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmation I-10 Reaffirmed: Res. 215, A-11 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12

Policy D-370.987, “Study Incentives for Cadaveric Organ Donation”
Our AMA will place high on its legislative agenda modification of the National Organ Transplantation Act to rescind prohibition of “valuable consideration” for cadaveric organ donation, so that pilot studies of financial incentives for donation can be carried out. (Res. 10, A-08)

Policy H-370.958, “Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool”
1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation.
2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates.
3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. (Res. 7, I-15)
Subject: Advocacy for Seamless Interface between Physician Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) (Resolution 212-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee B (R. Dale Blasier, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 212-A-17, “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,” which was sponsored by the American College of Legal Medicine, and which directed the AMA to:

Join the American College of Legal Medicine to advocate federally-mandated interfaces between provider/dispenser electronic health record systems in the clinical, hospital and pharmacy environments and state prescription drug databases and/or prescription drug management plans;

Advocate that the cost of generating these interfaces be borne by the commercial EHR and dispensing program providers;

Advocate that the interface should include automatic query of any opioid prescription, from a provider against the state prescription drug database/prescription drug management plan (PDMP) to determine whether such a patient has received such a medication, or another Schedule II drug from any provider in the preceding ninety (90) days;

Advocate that the prescriber and the patient’s EHR-listed dispensing pharmacy should then be notified of the existence of the referenced patient in the relevant PDMP database, the substance of the previous prescription(s) (including the medication name, number dispensed and prescriber’s directions for use) in real time and prior to the patient receiving such medication;

Advocate that the electronic record management program at the pharmacy filling the relevant prescription, contemporaneously as it enters the filling of the prescription by the pharmacist, likewise be required to automatically query the state PDMP as a secondary mechanism to prevent inappropriate prescribing, forgery, duplication and/or too great a frequency of use of the involved controlled medication;

Work with ACLM and other concerned societies to urge Congress to timely enact and implement such a statutory scheme supported by a workable and concise regulatory framework, chiefly concentrating on the interfacing of all applicable electronic health record
and pharmaceutical dispensing systems with every individual state’s PDMP, thereafter
designating a timeframe wherein all treating providers and dispensing pharmacists would be
required to perform such queries, in concert with the routine ordering of and filling of a
controlled substance to be used in the treatment of patients;

Advocate that oversight of the appropriate prescribing of and filling of prescriptions for
controlled substances remain with the involved individual federal and state criminal law
enforcement agencies, the involved state departments of health, or similar entities and the
involved relevant state provider and/or pharmacy licensure authorities; and

Advocate that statistics be maintained and reviewed on a periodic basis by state PDMP
personnel and relayed to state departments of health or agencies similarly situated so as to
identify and possibly treat those patients identified through this screening mechanism as
potential drug abusers and/or at risk of addiction.

This report summarizes the work the AMA has done in support of ensuring accurate, reliable
Prescription Drug Monitoring Programs (PDMPs) that support physicians and their patients. It also
addresses many of the complexities raised in the original resolution, including PDMP evolution,
integration with electronic health records (EHRs) and electronic prescribing of controlled
substances (EPCS). The report also provides relevant AMA policy and presents policy
recommendations.

DISCUSSION

Integrating electronic systems that support efforts to end the opioid epidemic continues to be a
major goal of AMA advocacy. To effectively support physician efforts to end the epidemic of
opioid overdose deaths, electronic systems need to be interoperable and integrated into normal
medical practice workflows. There has been progress, but effective integration remains extremely
rare.

Too often, information exchanged with EHRs is not well incorporated into the physician’s
workflow. Important information, including PDMP data, often requires multiple “clicks,” opening
multiple windows, and requiring separate logins even before the physician finds what he or she is
looking for—and that situation must be repeated for each patient and every prescription for a
controlled substance. Effective PDMP and EHR integration means that the workflow must achieve
“functional interoperability,” or the ability for systems to exchange, incorporate and display data in
a meaningful and contextual manner.

Many consider the ideal practice to be a “one-click” solution with PDMP data and EPCS integrated
into physicians’ EHR systems. However, EHR vendors currently are pulled in too many directions
to focus on this need. Federal regulations require vendors to spend considerable time developing
EHRs that meet administrative requirements. To achieve the ideal, more must be done to reduce the
regulatory pressure on health IT development, allowing vendors flexibility to respond to physician
and patient needs, rather than spending the bulk of their time complying with administrative
demands.

One area where there has been significant progress is interoperability between the various state
PDMPs. According to the National Association of Boards of Pharmacy, 44 states now can securely
share PDMP information across state lines.¹ PDMP use among physicians and other health care
professionals has significantly increased in recent years, with more than 136 million queries taking
place in 2016,² the most recent year for which data are available.
Progress has been considerably slower in achieving EPCS uptake, however, largely due to outdated regulations from the Drug Enforcement Administration (DEA). The combination of personal identification numbers (PINs), passwords, and biometrics required to meet DEA standards for “two-factor authentication” increase EPCS security but add to workflow disruptions and increase costs. DEA EPCS requirements include onerous limits on use of biometric devices, which must comply with federal standards that set an unnecessarily high bar and prevent use of user-friendly consumer electronics already found in physicians’ offices for two-factor authentication. The biometric fingerprint scanners found on these consumer devices, i.e., smart phones, tablets, and laptop computers, are used for secure access to other sensitive information, like banking and medical records, but typically do not comport with rigid rules for EPCS.

The AMA views EPCS as important to support high-quality patient care. Physicians commonly report that they are frustrated that they can e-prescribe non-controlled substance medications but must still use written prescriptions for controlled substances. More than 70 percent of physicians are e-prescribing non-controlled drugs but only 20 percent use EPCS. One reason for this is due to the fact that not all EHR vendors understand or can satisfy EPCS requirements—state EPCS mandates have increased uptake, but implementation has been delayed due to questions about system certification, cost to providers, and patient concerns, i.e., transferring prescriptions between pharmacies. Moreover, EHR vendor processes for EPCS do not always align well with normal e-prescribing workflows—often physicians must start new computer programs and windows each time they use EPCS. Cumbersome workflows and applications that do not take physician needs into account impede EPCS uptake. Finally, although EPCS reduces prescription fraud and diversion, it is less clear how it affects valid prescriptions for opioid analgesics. For example, does the prescriber using EPCS put in a dose and duration or are numbers suggested by the EPCS system and, if so, how are these amounts derived? These are among the questions the AMA has been asking from vendors and physicians.

To help resolve other barriers, the AMA and the President’s Commission on Combating Drug Addiction and the Opioid Crisis have recommended the DEA modify EPCS regulations in order to reduce barriers to EPCS adoption. The AMA asked DEA to reexamine the scope of technology that is compliant with EPCS requirements and allow use of lower-cost, high-performing biometric devices in two-factor authentication. The AMA also believes that there must be further study to evaluate the variations in how EPCS systems handle initial dosing, i.e., are opioid doses or durations auto-populated in EPCS systems and, if so, are the amounts appropriate.

A final point is that the AMA has made clear to the DEA that its requirements for biometric devices limit user-friendly consumer electronics already found in physicians’ offices, such as fingerprint readers on laptop computers and mobile phones, from being utilized for two-factor authentication in EPCS. This and other rules contribute to cumbersome workflows and applications which are an impediment to physician EPCS uptake. Encouraging EPCS uptake and interoperability of PDMP databases and electronic health records would improve the integration of controlled substance use data into practice workflows and clinical decision-making.

The AMA also continues its efforts in support of making PDMPs better clinical tools. The use of PDMPs continues to increase in states with and without mandates—tied mainly to quality of the PDMP as a decision-support tool. Important policies that have led to improved PDMP workflow and data reliability include delegate access, data input by pharmacists within 24 hours, and sharing of PDMP information by 44 states. PDMP usability continues to improve, but access in rural and other areas may be affected by lack of access to broadband and other technologies. Consistent, long-term funding of state PDMPs is also a concern—most states depend on federal grants for ongoing maintenance and improvements. The AMA also continues to try and identify best
practices in designing PDMPs to identify risk including: distinguishing between uncoordinated care, misuse, and “doctor shopping,” identifying opportunities for referrals to specialized care; providing reports to prescribers to better inform prescribing decisions; and conducting public health surveillance.4

One best practice is PDMP and EHR integration, but that remains largely elusive. It is not clear, for example, how many PDMPs are integrated into EHRs, which makes identification of best practices challenging given the variety of EHR systems in the market. Each state PDMP may require a slightly different interface to connect to an EHR. With over 600 different EHRs on the market, the number of custom EHR/PDMP interfaces can reach into the thousands. Custom software development is time-consuming and expensive—with costs being passed down onto the physician. Without PDMP and EHR integration, physicians must use multiple usernames and passwords to shuttle between different systems, often having to re-enter login information if one system times out while they are using the other one. This results in increased time to enter information, decreased satisfaction with the technology, and potentially less use of the systems.

In addition, EHRs are generally not interoperable between different organizations, making coordination between primary care physicians, pain medicine physicians, addiction medicine physicians and other providers much more difficult. When PDMP and EHR integration does exist (e.g., Oregon’s EDIE), the patient, public health and cost utilization benefits are extremely positive.5 This integration requires time and broad, institutional support. For example, the state of Washington’s integration project with the state Health Information Exchange (HIE) began in 2012. As of August 2017, more than 90 percent of emergency departments include PDMP data in the EHR using data through the HIE.6 The state’s major health systems still are working to accomplish this integration.

To help resolve some of these issues, the AMA advocates for consistent and sufficient appropriations to support state efforts to maintain and improve state-based PDMPs, including broad state-based grants to improve statewide HIEs and the ability to integrate HIE data into the EHR of statewide emergency departments and other providers. The AMA also would support a U.S. Government Accountability Office study on best practices for small and large physician practices on using PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying how PDMPs can distinguish uncoordinated care from misuse or “doctor shopping” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. In addition, there is a need to evaluate the variations in state-based PDMP technology and work with the health IT industry to discuss “common understanding” of how each PDMP works—providing transparency for EHR vendors to facilitate development of custom connections between their products and PDMP software. This could include funding for programs that pilot test low-cost technologies to better integrate EHRs and PDMPs as well as efforts to identify burdensome federal regulations that prevent EHRs from being designed and developed to meet physician and patient needs.

The AMA also has been engaged in the SMART project to help EHR systems work better for physicians and patients. A key component of this effort is the development of a flexible information infrastructure that allows for free, open development of plug and play applications (apps) to increase interoperability among health care technologies, including EHRs, in a more cost-effective way. The infrastructure development specific to PDMPs is part of both ongoing research as well as work by states working to achieve more comprehensive data integration.7 In addition, the Office of the National Coordinator for Health Information Technology has compiled multiple sources and pilot examples for PDMP and EHR integration.8 The pilot examples, not surprisingly,
found that PDMPs were most helpful when they were integrated into physicians’ workflow as well as EHRs.

AMA POLICY

The AMA House of Delegates has provided strong guidance to the AMA that reflects the issues raised by the original resolution that is the subject of this report. Relevant policies include:

H-120.957, “Prescription of Schedule II Medications by Fax and Electronic Data Transmission,” which “encourages the Drug Enforcement Administration to support two factor authentication that is easier to implement than the current DEA and EPCS security requirements; and because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, does not support the use of “hard copy” facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations.” In addition, H-95.928, “Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing,” provides that the AMA support multiple facets of PDMP development, including interoperability, assisting physicians and pharmacists in identifying “when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame.” In addition, D-478.972, “EHR Interoperability,” calls for the AMA to continue efforts in support of EHR interoperability standards, reducing excessive costs and generally reducing barriers to EHR adoption. Finally, Policy D-478.994, “Health Information Technology,” broadly notes AMA support for “legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology,” which reasonably would include PDMP, EPCS and EHR uptake.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 212-A-17, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying how PDMPs can distinguish team-based care from uncoordinated care, misuse, or “doctor shopping,” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. (Directive to Take Action)

2. That our AMA urge EHR vendors to increase transparency of custom connections between their products and PDMP software. (Directive to Take Action)

3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. (New HOD Policy)

Fiscal Note: Less than $500.
REFERENCES

1 National Association Boards of Pharmacy. Available at https://nabp.pharmacy/initiatives/pmp-interconnect/
8 PDMPConnect. Office the National Coordinator for Health Information Technology. Available at https://www.healthit.gov/pdmp/PDMPConnect
REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-18

Subject: Integration of Drug Price Information into Electronic Medical Records/
Barriers to Price Transparency/Bidirectional Communication for EHR Software
and Pharmacies/Health Plan, Pharmacy, Electronic Health Records Integration
(Resolution 219-A-17; Resolution 213-I-17; Resolution 203-I-17; Resolution
205-I-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting Resolution 219-A-17, “Integration of Drug Price Information into
Electronic Medical Records,” was referred by the House of Delegates (HOD). Resolution
219-A-17 was introduced by the Medical Student Section and asks the American Medical
Association (AMA) to support the incorporation of estimated patient out-of-pocket drug costs into
electronic medical records (EMR) and collaborate with invested stakeholders, such as physician
groups, EMR vendors, hospitals, insurers, and governing bodies to integrate estimated out-of-
pocket drug costs into electronic medical records in order to reduce patient cost burden.

At the 2017 Interim Meeting, Resolution 213-I-17, “Barriers to Price Transparency,” was
introduced by the American Academy of Dermatology, American Society of Dermatologic Surgery
Association, American College of Mohs Surgery, American Society of Dermatopathology, and the
Society for Investigative Dermatology. The third resolve of Resolution 213-I-17 was referred by
the HOD and asks the AMA to support access to real-time prescription drug pricing and cost
transparency at the point of prescribing.

Also at the 2017 Interim Meeting, Resolutions 203-I-17, “Bidirectional Communication for EHR
Software and Pharmacies,” and 205-I-17, “Health Plan, Pharmacy, Electronic Health Records
Integration,” were referred together.

Resolution 203-I-17 was introduced by the Medical Society of Virginia, the Kentucky Medical
Association, the North Carolina Medical Society, the American Urological Association, and the
American Association of Clinical Urologists. Resolution 203-I-17 asks the AMA to engage the
American Pharmacy Association, and any other relevant stakeholders, to encourage both electronic
health record (EHR) and pharmacy software vendors to have bidirectional communication for an
accurate and current medication list in the patient’s EHR.

Resolution 205-I-17 was introduced by the Medical Society of Virginia, the Kentucky Medical
Association, the American Urological Association, and the American Association of Clinical
Urologists. Resolution 205-I-17 asks the AMA to advocate that health plans, pharmacies, and EHR
vendors integrate their technology programs so that physicians have current and real time access to
covered medications for patients within a specific health plan. Resolution 205-I-17 also requests
that the AMA advocate that health plans make patient cost information readily available via this
technology so that physicians and their patients may work together to choose the most cost-
effective medically appropriate medication for patient care.

All resolutions were referred for report back at the 2018 Annual Meeting. As the referred resolves
in each resolution deal with components of a common issue, this report will address the topic as a
whole, and present recommendations accordingly.

BACKGROUND

Prescription drug costs in the United States are significant and rising. Some research shows the
patient out-of-pocket prescription costs are decreasing, although overall drug spending has
increased\(^1\) and approximately 25 percent of Americans who regularly take prescription medications
saw a price increase from 2016 to 2017.\(^2\) There is significant correlation between increased patient
prescription cost sharing and decreased medication adherence,\(^2,3\) suggesting an adverse effect on
patient outcomes.

Many physicians report not having access to drug price information at the point of prescribing,\(^4\)
often preventing them from sharing the information with the patient and gaining awareness of
whether a patient can afford the medication. Studies show increased physician awareness of drug
prices changes prescribing behavior and reduces overall medication expenditures.\(^5\) The AMA
recognizes that physicians can enhance patient-centered care by balancing costs and the potential
for patient adherence to prescriptions in their decision-making related to maximizing health
outcomes and quality of care for patients.

Improving drug price transparency would increase patient and physician awareness of the overall
costs associated with different prescription drug treatment options and ultimately facilitate better-
informing, shared treatment decisions that could help reduce prescription drug spending. Integrating
drug price information into EHRs would support point-of-prescription cost transparency that could
increase a physician’s ability to provide price information to patients. Although various barriers
have historically inhibited the provision of drug price information at the point of prescribing, key
stakeholders have taken significant steps in recent months towards overcoming these barriers and
implementing solutions.

AMA POLICY

The AMA is committed to working with federal and state agencies, policymakers and other
relevant stakeholders to identify and promote adoption of policies to address the already high and
escalating costs of generic prescription drugs (Policy H-110.988, “Controlling the Skyrocketing
Costs of Generic Prescription Drugs”). The AMA supports increasing physician awareness about
the cost of drugs prescribed for their patients (Policy H-110.996, “Cost of Prescription Drugs”),
and encourages physicians to become familiar with the cost of drugs in their communities and to
consider prescribing the least expensive drug treatment available (Policy H-110.997, “Cost of
Prescription Drugs”). The AMA emphasizes the importance of value-based decision-making in
health care, and the need for physicians to have easy access to and review the best available data
associated with costs at the point of decision-making, which necessitates cost data to be delivered
in a reasonable and useable manner by third-party payers and purchasers. AMA policy also asserts
that physicians should seek opportunities to improve their information technology infrastructures to
include new and innovative technologies, such as personal health records and other health
information technology initiatives, to facilitate increased access to needed and useable evidence
and information at the point of decision-making (Policy H-450.938, “Value-Based Decision-

Making in the Health Care System”). The AMA also encourages physicians to communicate information about the cost of their professional services, including prescriptions, to individual patients, and encourages EHR vendors to include features that assist in facilitating price transparency for physicians and patients (Policy D-155.987, “Price Transparency”).

The AMA is dedicated to actively engaging with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency, and helping ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide (Policy D-155.987, “Price Transparency”). It is AMA policy that in order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, and pharmacies should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to their provision. There should be a similar requirement that insurers make available in standard format information on the amount of payment provided toward each type of service identified as a covered benefit (Policy H-373.998, “Patient Information and Choice”). The AMA encourages implementation of practices that increase price transparency among other stakeholders, including pharmaceutical companies, pharmacy benefit managers and health insurance companies (Policy H-110.987, “Pharmaceutical Costs”). Additionally, the AMA advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay, and is committed to pursuing legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication (Policy H-110.991, “Price of Medicine”). The AMA is also committed to working with EHR vendors to enhance transparency and establish processes to achieve data portability (Policy D-478.995, “National Health Information Technology”).

DISCUSSION

Lack of transparency in prescription drug pricing is a major contributor to the increasingly high prices of drugs. Prescription price transparency is an important factor in lowering patients’ out-of-pocket costs and preventing prescription abandonment, a common cause of medication non-adherence, which negatively impacts patient safety and costs an estimated $300 billion each year in avoidable medical spending.

Efforts can be made at multiple levels to improve the visibility of drug prices. For example, transparency of drug prices can be increased at the point-of-purchase level, when patients are interacting with the pharmacist to fill or refill a prescription. Historically, gag clauses in pharmacy benefit manager (PBM) contracts have prevented pharmacists in many states from informing consumers that the drug they want to purchase could be purchased at a lower cost if the consumer paid out of pocket rather than through their insurance plan. Some states are considering legislation, and several have passed laws, that ban restrictive gag clauses in PBM contracts with pharmacies. Eliminating these restrictions allows pharmacists the freedom to inform patients about the least expensive way to obtain the medication they have been prescribed. At the point of prescribing, when a physician is discussing treatment options during a clinical visit, the price of a drug could be a deciding factor in whether the treatment is pursued; however, prescribers are largely unaware of the prices associated with the medications they prescribe and have difficulty estimating costs with accuracy. Some EHR platforms display limited high-level drug price information, such as co-pay tiers and dollar sign rating scales, giving a general estimate or range for the patient’s portion of a drug’s cost. These data are based on static “flat” files provided by PBMs to EHR vendors using the National Council for Prescription Drug Programs (NCPDP) Formulary and Benefit standard. This information is not always up to date or accurate,
however, since payers or PBMs may change a drug formulary or reclassify a particular prescription without the physician’s or patient’s knowledge and/or without providing updated formulary data to EHR vendors. This can further hinder the provision of accurate drug cost information to patients and physicians, presenting another opportunity for improved transparency.

Universally integrating real-time drug price information, along with improving the reliability and granularity of the currently available formulary and benefit information, into EHR systems would provide physicians with a more accurate estimate of a patient’s potential cost for a given medication. Since 2014, NCPDP has been working on a real-time pharmacy benefit check solution through the work of their Real-Time Benefit Check Analysis Task Group (more recently named the Real-Time Prescription Benefit Standard Task Group). This group’s goal is to develop an electronic standard for communicating real-time drug pricing information to physicians at the point-of-prescribing in EHR systems. Data points would include formulary status, tier structure, restrictions such as prior authorization and step therapy requirements, patient co-pays, and therapeutic alternatives that may be more affordable for the patient.

While NCPDP continues developing a real-time pharmacy benefit standard, vendors and PBMs are piloting this technology in proprietary formats. In 2017, Surescripts, six major EHR vendors including Allscripts, Cerner, GE, Epic, Practice Fusion and Aprima, along with CVS Health, partnered to deliver a system that provides prescribers with the cost of medications, specifically based on the patient’s insurance coverage, as well as other therapeutic treatment options to ensure the patient and physician can decide together the most appropriate and affordable course of treatment. This collaborative service is planned to be available in 2018. This development is an important step toward a sustainable solution; however, for it to be viable and universally beneficial the data must be available across all EHR vendors for all patients with all payer information.

There is mixed evidence on whether providing prescribers with cost information at the point of prescribing results in significant changes to prescribing behavior, overall costs, or improvements to medication adherence. One study showed evidence that providing physicians with information about drug prices increased generic prescribing and decreased orders for diagnostic tests, and that “gatekeeper” physicians reduced use of hospital and specialist services when regularly presented with prescription cost information. Another study demonstrated that having access to the charges associated with patient care changed practice patterns and decreased patient charges, thereby improving cost containment efforts. An analysis of prescriptions and use of a point-of-care electronic drug reference database for over 125,000 U.S. physicians found that physicians using the database prescribed a significantly more diverse set of products, were faster to begin prescribing new generic drugs, and also had a greater propensity to prescribe generics. The researchers attributed this finding to the database users’ access to non-clinical information such as drug price and insurance formulary data.

However, a separate study reviewed the total and out-of-pocket cost changes for diabetes patients whose physicians had access to drug formulary and price information and found that while the total drug costs increased at a lower rate, having access to the cost information did not reduce the patient out-of-pocket cost or increase medication adherence rates. Similarly, a study published in *JAMA Internal Medicine* demonstrated that displaying Medicare allowable fees for inpatient laboratory tests did not lead to a significant change in overall clinician ordering behavior or associated fees. Overall, researchers have found that while access to drug price and coverage data may influence prescriber decisions, providing price information alone is not enough and that more comprehensive approaches are in order. Some conclude that transparency in price is most beneficial when combined with education and an audit/feedback mechanism for prescribers. Others assert that prices for individual components of care provide an incomplete picture of the patient’s out-of-
pocket responsibility, and that seeing prices for episodes or bundles of care could allow patients
and physicians to assess value and treatment together.\textsuperscript{17} 

The issue of drug price transparency is one of great importance to the AMA and our current
advocacy efforts reflect our commitment to addressing the issue at the state and federal levels. The
Chair of the AMA Board of Trustees presented testimony at the December 2017 Energy and
Commerce hearing on drug pricing to ensure AMA’s position and the voice of physicians
continues to be represented. Another example of this work is the AMA’s interactive grassroots
website TruthinRx.org, which urges improved drug pricing transparency among pharmaceutical
manufacturers, pharmacy benefit managers, and health plans and offers patients the opportunity to
share their stories of how rising prices affect their physical and financial health. At the state level,
the AMA’s model legislation on drug pricing transparency seeks to provide patients with relevant,
accurate information about the manufacturing, production, advertising, and other associated costs
relating to prescription medications and institute consumer protections for sudden drug price
fluctuations.

The AMA’s advocacy efforts on prior authorization reform address the need for accurate formulary
data in EHRs. In January 2017 the AMA, in collaboration with 16 other organizations representing
physicians, hospitals, pharmacists, medical groups, and patients, released a set of 21 Prior
Authorization and Utilization Management Reform Principles. Of note is Principle 9, which states
“Utilization review entities should provide, and vendors should display, accurate, patient-specific,
and up-to-date formularies that include prior authorization and step therapy requirements in [EHR]
systems for purposes that include e-prescribing.” The AMA has used these principles to spur
certain conversations with health plans about “right-sizing” prior authorization programs. One outcome of
these discussions was the January 2018 release of the Consensus Statement on Improving the Prior
Authorization Process by the AMA, American Hospital Association, America’s Health Insurance
Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group
Management Association. The consensus document reflects an agreement between national
associations representing both providers and health plans on the need to reform prior authorization
programs in multiple ways, including advancing automation to improve transparency and
efficiency. Specifically, the consensus statement “[e]ncourage[s] the communication of up-to-date
prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers,
relative costs, and covered alternatives . . . to EHR, pharmacy system, and other vendors to
promote the accessibility of this information to health care providers at the point-of-care via
integration into ordering and dispensing technology interfaces.” This reflects the widespread
agreement among providers and health plans about the need for accurate drug pricing information
in EHRs.

The AMA is actively involved in standards development work and direct discussions with vendors
to improve formulary data technology. The AMA participates in meetings of the NCPDP’s Real-
Time Prescription Benefit Standard Task Group and the Formulary and Benefit Task Group to
ensure the physician voice is represented in the development of standards and solutions. The AMA
dedicates significant resources to improving usability, interoperability and value in EHRs.
Incorporating prescription drug price information into EHRs will enhance the AMA’s efforts to
increase the value and utility of these systems.

The AMA recognizes the need for more knowledge about the current availability and accessibility
of the features described in these resolutions, including EHR, pharmacy and payer functionalities
that enable integration of price, insurance coverage, formulary tier and drug utilization
management policies, and patient cost information. As a more robust knowledge base is obtained
as a result of private sector initiatives such as that of Surescripts and others, the AMA will
encourage collaboration with other vendors and other key stakeholders to develop a plan for improving the availability and accessibility of this important information to all physicians. This effort, along with our existing commitment to pursuing legislation to increase price transparency at the payer and pharmacy levels, would further the AMA’s strategic goals to reduce health care costs and improve health outcomes.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 219-A-17, 203-I-17, 205-I-17, and 213-I-17, and that the remainder of the report be filed.


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

3. That our AMA collaborate with other interested stakeholders to develop and implement a strategic plan for improving the availability and accessibility of real-time prescription cost information at the point of care. (Directive to Take Action)

Fiscal note: Modest – Between $1,000 and $5,000
REFERENCES

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-18

Subject: Advanced Practice Registered Nurse Compact

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

This report is submitted for the information of the House of Delegates. So as not to expose sensitive advocacy strategies and potential future resources, a fuller accounting of the Scope of Practice Summit (“Summit”) described herein will take place through AMA meetings dedicated to advocacy and scope of practice, as well as the confines of the Scope of Practice Partnership (SOPP).

Policy adopted at the 2017 Interim Meeting called on the American Medical Association to convene an in-person meeting of relevant physician stakeholders to initiate creation of a consistent national strategy to effectively oppose efforts to grant independent practice to non-physician practitioners. (Policy H-35.988, “Independent Practice of Medicine by Advanced Practice Registered Nurses”).

The resultant Summit was held March 20, 2018 at AMA headquarters in Chicago. The SOPP provided funding to support the Summit. In addition, the SOPP awarded 14 scholarships to state medical associations that otherwise would have been unable to attend.

Attendance included 81 physicians, executive staff, and government affairs staff from 32 state medical associations, 16 national medical specialty societies, and the American Osteopathic Association. Representatives of the AMA Board of Trustees and Council on Legislation, and AMA staff from Advocacy, Office of General Counsel, Physician Engagement, and Enterprise Communications and Marketing also attended the Summit.

William E. Kobler, MD, member, AMA Board of Trustees and chair of the SOPP, served as chair of the Summit. Dr. Kobler led a planning committee composed of executive staff of the American Academy of Family Physicians, American Academy of Ophthalmology, American Congress of Obstetricians and Gynecologists, American Psychiatric Association, American Society of Anesthesiologists, California Medical Association, Medical Association of Georgia, New Mexico Medical Society, Ohio State Medical Association, and Medical Society of Virginia. This planning committee was instrumental in shaping the Summit agenda, and the Board of Trustees thanks them for their time and effort.

With the assistance of a strategic research firm prior to the Summit, the AMA Advocacy Resource Center conducted a survey of all associations invited to the Summit. Feedback from 60 respondents about scope of practice advocacy and trends was synthesized in a presentation to kick-off the Summit. This valuable insight was also utilized throughout the Summit’s strategic planning session.
Meeting attendees heard presentations about the considerable scope of practice advocacy resources of the AMA Advocacy Resource Center and SOPP, including the Health Workforce Mapper, Geographic Mapping Initiative, Scope of Practice Data Series Modules, model bills, state law charts, issue briefs, talking points, public opinion research, and comprehensive state legislative campaigns including the Physician-Led Team Campaign and Truth in Advertising Campaign, and grant funding. Attendees also heard a case study from a state medical association that heavily utilized SOPP resources and a SOPP grant to fight a nurse practitioner independence bill; and a panel of national medical specialty society representatives discussing scope priorities and trends.

The afternoon was dedicated to a strategy session, in which facilitated small and large group discussions identified strengths, opportunities, weaknesses, and threats related to scope of practice advocacy. The strategy session also identified ways in which to amplify strengths and opportunities within organized medicine while addressing weaknesses and internal and external threats. A professional facilitator with government affairs expertise moderated the discussion.

Results of a meeting evaluation were positive. Of the responses, 98 percent reported that the conference fully or partially fulfilled their reason for attending, and 85 percent would recommend the meeting to colleagues. 95 percent of attendees were pleased with the quality of the presentation and the scope of the information presented. 88 percent of respondents left with a somewhat or much better view of the AMA; the remainder reported that their opinion of the AMA was unchanged.

The Board of Trustees recommends that Policy H-35.988(2) be rescinded, having been accomplished through the Scope of Practice Summit and this report.

RECOMMENDATION

The Board of Trustees recommends that Policy H-35.988(2), “Independent Practice of Medicine by Advanced Practice Registered Nurses,” be rescinded and that the remainder of this report be filed. (Rescind HOD Policy)
REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-18

Subject: Protection of Clinician-Patient Privilege (Resolution 237-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 237-A-17, “Protection of Clinician-Patient Privilege,” for report back at the 2018 Annual Meeting. This resolution was introduced by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont Delegations and asked that our American Medical Association (AMA):

Advocate to the relevant national bodies for the clinician-patient privilege to be regulated according to the privacy protections in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) without regard to where care is received.

This report provides information about the privacy protections and exceptions thereto found in the Family Education Rights and Privacy Act (FERPA) in post-secondary educational settings. It also compares such protections and exceptions to those found in HIPAA. Finally, it discusses which of the two standards is more appropriate for the AMA to support.

BACKGROUND

FERPA is a federal law that applies to educational institutions—including most public and private post-secondary institutions—that receive funding from the U.S. Department of Education. It protects the privacy of information found within students’ “education records,” which is broadly defined to mean those records that are (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution.1 FERPA prohibits a post-secondary institution from disclosing personally identifiable information (PII) from a student’s education records absent that student’s written consent, unless an exception applies.2 Education records can include medical records (for example, immunization records), but are separate and distinct from “treatment records.” Treatment records are defined in post-secondary institutions as those made or maintained by a physician, psychiatrist, psychologist, or other recognized professional acting in his or her professional capacity and in connection with treatment of a student at the institution.3 By definition, these records may be disclosed only to individuals providing treatment to the student (not even to the student him or herself), unless the student provides written consent or an exception applies.4 Once a disclosure is made to anyone other than the student’s treating clinicians, the record is no longer considered a treatment record, but rather an education record subject to FERPA’s general disclosure rules.5
As noted above, there are instances in which a school may disclose both education and treatment records even when the student does not provide written consent. Examples include:

- For the legitimate educational interests of other educational institutions;
- To make financial aid determinations;
- To authorized representatives of the United States government;
- To parents of dependent students;
- To comply with a judicial order or lawfully issued subpoena;
- If the educational institution initiates legal action against a parent or student; and
- If a parent or student initiates legal action against the educational institution.

HIPAA, the federal privacy law applicable to most medical records, prohibits the use and disclosure of protected health information (PHI) by covered entities (e.g., clinicians and health care facilities) absent written patient authorization, unless an exception applies. Common exceptions include:

- Treatment (including disclosure of information to other health care providers);
- Payment;
- Health care operations (including for litigation purposes where the covered entity is a party to the proceedings);
- For public health purposes;
- To authorized representatives of the United States government;
- To parents of minors; and
- To comply with a judicial order or lawfully issued subpoena.

DISCUSSION

Both HIPAA and FERPA permit disclosure of medical information without a patient’s written authorization for certain purposes. Specifically, with respect to disclosures for legal proceedings, HIPAA requires that a covered entity disclose only the minimum amount of information necessary to accomplish the intended purpose of the disclosure. Guidance from the U.S. Department of Education also notes that “without a court order or written consent, [educational] institutions that are involved in litigation between the institution and the student should not share, without consent, student medical records with the institution’s attorneys or courts unless the litigation in question relates directly to the medical treatment itself…and even then should disclose only those records that are relevant and necessary to the litigation.” This guidance also notes that “FERPA’s school official exception to consent should be construed to offer protections that are similar to those provided to medical records in the context of litigation between a covered health care provider, such as a hospital, and a patient under [HIPAA].”

CONCLUSION

The patient should always be at the center of any privacy policy adopted by the AMA, and indeed, the AMA has strong policy protecting the privacy of patient information, included in the appendix. Regardless of the clinical care setting, whether it is an educational setting, a substance abuse clinic, or a physician’s office, the AMA should continue to advocate for HIPAA’s privacy protections to be the minimal level of privacy afforded to a patient. This position will permit more stringent privacy laws for patients where appropriate—for example, more protective state laws or federal laws, such as 42 CFR Part 2, which protects patients who seek treatment at substance abuse facilities. The AMA should also continue to ensure that any information disclosed without a
patient’s written consent is the minimum necessary to accomplish the disclosure’s intended purpose.

RECOMMENDATIONS

The Board of Trustees recommends that Policy H-315.983 be amended in lieu of Resolution 237-A-17 and the remainder of the report be filed:

Policy H-315.983, “Patient Privacy and Confidentiality”

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

Fiscal Note: Less than $500.
REFERENCES

1 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
2 34 CFR 99.30, 20 USC 1232g(b); 20 USC 1232g(d).
3 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
4 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
6 34 CFR 99.31; 20 USC 1232g(b).
7 45 CFR 164.502(a).
8 45 CFR 164.502(b); 45 164.514(d); see also “May a covered entity that is a plaintiff or defendant in a legal proceeding use or disclose protected health information for the litigation?”, available at www.hhs.gov/hipaa/for-professionals/faq/705/may-a-covered-entity-in-a-legal-proceeding-use-protected-health-information/index.html, accessed February 25, 2018.

APPENDIX — AMA POLICY

Policy H-315.983, “Patient Privacy and Confidentiality”
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients,
physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

Policy H-320.994, “Confidentiality”

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

Policy H-315.975, “Police, Payer, and Government Access to Patient Health Information”

1. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

2. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

3. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually
identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

4. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

5. Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Policy H-60.965, “Confidential Health Services for Adolescents”
Our AMA: (1) reaffirms that confidential care for adolescents is critical to improving their health; (2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law; (3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care; (4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements); (5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician; (6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis; (7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice; (8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and (9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

Policy H-315.965, “Modernizing Privacy Regulations for Addiction Treatment Records”
Our AMA supports: (1) regulatory and legislative changes that better balance patients’ privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders; (2) regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders; and (3) continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system.
REPORT OF THE BOARD OF TRUSTEES

Subject: Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

INTRODUCTION

At the 2017 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-120.935, “Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care,” which directed the AMA to:

1. Take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.

2. Work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to:

   a. Identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine, and

   b. Prohibit pharmacy actions that are unilateral medical decisions; and

3. Report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination.

This report summarizes actions that the AMA has taken to preserve physician autonomy, highlights relevant AMA policy, and presents policy recommendations. Because the intent of the resolution and reference committee testimony primarily focused on situations related to the prescribing and dispensing of opioid analgesics, this report will similarly focus on that issue.

DISCUSSION

The AMA has been working closely with the nation’s leading pharmacy and pharmacist organizations for years in support of the therapeutic triad, that is, working to enhance the collaborative roles of physicians, pharmacists and patients to help ensure safe and appropriate medication use. With respect to prescriptions for opioid analgesics, the AMA began receiving increasing reports about pharmacists contacting physicians to request additional information about patient prescriptions for controlled substances (before they would authorize dispensing) as far back as 2013. In response, the AMA and the National Association of Boards of Pharmacy organized a
series of discussions with multiple stakeholders designed to increase awareness of factors contributing to these types of requests and to improve communication channels. Participating organizations included:

- American Academy of Family Physicians
- American College of Emergency Physicians
- American Medical Association
- American Osteopathic Association
- American Pharmacists Association
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Cardinal Health
- CVS Health
- Drug Enforcement Administration
- Federation of State Medical Boards
- Healthcare Distribution Management Association
- National Association of Boards of Pharmacy
- National Association of Chain Drug Stores
- National Community Pharmacists Association
- Pharmaceutical Care Management Association
- Rite Aid
- Walgreen Co.

The stakeholders initially met in October 2013, and subsequently met numerous times over the course of 2013 and 2014 to better understand the shared responsibilities of physicians and pharmacists to ensure that all controlled substances are prescribed and dispensed for a legitimate medical purpose. The stakeholders’ focus began with a review of a key provision within the Controlled Substances Act, which provides:

A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.¹ (emphasis added)

Participants engaged in a constructive dialogue and ultimately agreed and released a consensus statement (signed by nearly all of the organizations) about the challenges that physicians and pharmacists face in trying to understand and resolve “red flags” that may be apparent, and a broader array of aberrant behaviors that may manifest and raise concerns among physicians. Commonly agreed upon “red flags” have been constructed out of U.S. Drug Enforcement Administration (DEA) administrative actions and most are obvious, such as a clearly forged prescription or multiple people from out-of-state presenting prescriptions for large quantities of high-dose opioid analgesics. However, some behaviors (e.g., slurred speech, exhibiting signs of intoxication) or specific features of the prescription including drug combinations may raise questions for the pharmacist that may be unresolvable without obtaining further information from
the prescribing physician. In these cases, the organizations agreed that inter-professional dialogue was essential to resolve questions to the patient’s benefit. Stakeholders shared the consensus statement widely with the intent of increasing understanding of the shared legal responsibilities of physicians and pharmacists for controlled substance prescriptions. Subsequently, when the AMA received complaints from state medical societies or individual physicians, staff have enabled on multiple occasions direct collaboration between a retail pharmacy and the state medical society to investigate and intercede with the individual pharmacist or prescriber when necessary. An overarching goal is to ensure that legitimate inquiries by a pharmacist about a patient’s diagnosis or medical history that are necessary to fulfill their corresponding legal responsibility are not perceived as intrusive or unnecessary, and to foster communications that can help resolve potential contraindications and/or provide physicians with relevant information in a patient’s prescription history about which the physician may not be aware. Without question, such discussions can sometimes be challenging.

Publication of the *Centers for Disease Control Guideline For Prescribing Opioids For Chronic Pain* (CDC Guidelines) in March 2016, has changed the regulatory and clinical practice environment and led to new challenges for pain management and opioid prescribing, including the likelihood that some patients will have their prescriptions for opioid analogesics dispensed as written. Two of the CDC Guideline’s recommendations—which were developed as voluntary guidance and not a bright line threshold, according to CDC—make specific reference to prescriptions above a certain morphine milligram equivalent amount (Recommendation 5) and above a certain quantity (or days’ supply) (Recommendation 6). In comments to the CDC during the review period, the AMA expressed specific concerns about the unintended consequences of such thresholds—highlighting that future payer and legislative actions would likely align with the CDC Guidelines in ways that would not be patient centric.

Since the publication of the CDC Guidelines, more than 20 states have enacted opioid prescribing limits that include specific dose and/or quantity thresholds. What is notable is that nearly every state prescribing restriction is different, although most purport to have exceptions for patients with cancer; those who are in hospice or receiving palliative care; at end of life; or when the opioid is part of a treatment regimen for a substance use disorder. Furthermore, it is notable that opioid prescribing appears to have reached its zenith in 2012 (259 million prescriptions) with modest decreases every year since yielding a cumulative 17 percent decrease, between 2012 to 2016 (215 million prescriptions). It is beyond the scope of this report to analyze the lack of correlation between decreased opioid prescribing and increased opioid-related mortality, but the AMA remains deeply concerned that policymakers’ focus continues to be on reducing opioid supplies, with little or no emphasis on increasing access to multidisciplinary pain care, including non-opioid, and non-pharmacologic alternatives.

In addition to state laws that govern prescribing behavior, there has been significant activity by payers, pharmacies, and pharmacy benefit managers (PBMs) to adopt and implement opioid prescribing restrictions based on CDC Guidelines, including new policies in 2017 from the nation’s largest PBMs, CVS Caremark, Express Scripts, and Optum. This is in addition to prescription review policies that were previously implemented by pharmacies. Many payers also have instituted new prior authorization policies based on CDC Guidelines, including many state Medicaid plans, Blue Cross Blue Shield plans, and plans sponsored by United Health Care, Anthem, Aetna, Cigna, and others. In each case, the pharmacies, PBMs, and payers affirm their commitment to ending the opioid epidemic through increased vigilance regarding opioid prescribing, and many of the plans have touted their success in reducing opioid prescribing. The Board notes that the inevitable effect of any statutory, regulatory or other policy to restrict a practice will, in fact, lead to such a
restriction. What is less clear, however, is whether the restrictive policies have had a concomitant
effect of improving patients’ pain care, or (and beyond the scope of this report) whether those
policies have helped identify patients at risk of overdose and referred them to treatment for a
potential substance use disorder.

The AMA continues to work with pharmacy associations and business entities, including asking
the central question about whether the new policies are helping patients. The actions by
pharmacies, is in addition to legislative and regulatory activity limiting quantity and dose of opioid
analgesics, and in some cases, benzodiazepines. While the AMA remains concerned by actions to
apply one-size-fits-all solutions to the opioid epidemic, we are cognizant that many state medical
societies have been deeply engaged in the legislative process to help craft the resulting laws.
Pharmacy, PBM, and payer policies, however, have not received the benefit of public notice or
comment.

When comment is sought—such as through the federal government—the AMA makes its concerns
clear. One of the most recent examples was in response to the Centers for Medicare & Medicaid
Services (CMS) request for comment on a new electronic quality measure (eCQM) focused on the
degree of potential opioid overuse, and using 90 morphine milligram equivalents as the quality
measure standard, the AMA on February 9, 2018 emphasized:

Identifying those patients for whom opioid prescriptions exceed => 90 morphine milligram
equivalents (MME)/day may serve as an indicator of whether a patient is at risk of overdose
and should be co-prescribed naloxone, but the AMA believes that significant revisions and
testing are required prior to implementing this measure in any federal program. The measure
as constructed implies that patients who do not receive => 90 MME/day over a 90-day period
receive higher quality care. We do not believe that the measure, with its broad denominator
population and limited exclusions, adequately captures the recommendations from the
CDC. The recommendations allow for physicians to document a clinical rationale or
justification when 90 MME/day is exceeded; yet, the measure does not capture if a
justification exists nor does it provide a well-defined and targeted denominator.

While it is not yet known when CMS will publish the final measure, the AMA has and will
continue to stress the need for clinical decisions to have a clear rationale informed by the best
available evidence. Furthermore, use of the CDC Guidelines in this manner is also inconsistent
with the intended use of the Guidelines.

For example, the CDC Guidelines states:

Clinical decision making should be based on a relationship between the clinician and patient,
and an understanding of the patient’s clinical situation, functioning, and life context. The
recommendations in the guideline are voluntary, rather than prescriptive standards. They are
based on emerging evidence, including observational studies or randomized clinical trials
with notable limitations. Clinicians should consider the circumstances and unique needs of
each patient when providing care.

Additionally, the AMA has actively engaged with multiple pharmacies, public health, and other
organizations to advance policies increasing access to naloxone. It should be noted that the Board
and AMA Council on Legislation first approved AMA model state legislation, the Help Save Lives
from Overdose Act, in 2013, and revised and updated the model bill in subsequent years. In
partnership with more than two dozen state medical societies, pharmacy associations, and other
stakeholders ranging from the Federation of State Medical Boards, National Association of Boards
of Pharmacy, Walgreens, CVS, National Governors Association, and many others, the AMA model bill—or similar versions—are now law in every state in the nation. This type of collaborative effort has undoubtedly saved tens of thousands of lives. At the same time, the AMA continues to hear reports that some patients may not be able to afford naloxone due to the cost, lack of awareness of patient assistance programs or the ongoing stigma associated with naloxone. The AMA will continue to work to address these barriers to care so that when a patient needs access to naloxone, it will be available.

The AMA also has engaged in efforts by the National Association of Insurance Commissioners (NAIC) to revise their model legislation on the pharmacy benefit. AMA staff worked closely with other stakeholders, including many consumer and patient organizations, to advocate for the need to regulate utilization review (e.g. pharmacy benefit managers) that delay or decrease access to patient care and stand in the middle of the patient-physician decision making process. Additionally, AMA staff sought provisions that prevented continual formulary changes and other cost-saving tactics by payers that undercut physicians’ ability to ensure patients receive appropriate care. While many positive provisions supported by the AMA were incorporated into the final NAIC model, much work remains to be done as state legislatures consider pharmacy benefit regulations.

As such, the AMA has developed model legislation to address the issues of prior authorization, step therapy and other utilization management programs that have regularly impeded the practice of medicine by physicians, and just this year alone, is working with nearly a dozen state medical societies on state bills.

Additionally, over the last year the AMA has assembled a multi-stakeholder group that created a set of highly cited and widely distributed principles on utilization management reforms, all aimed at right-sizing payer involvement in patient care. In addition to policy discussions and changes that these principles have informed, they also served as the basis for a recent consensus statement among the American Medical Association, Blue Cross Blue Shield Association, America’s Health Insurance Plans, American Pharmacists Association, American Hospital Association, and Medical Group Management Association on the need to reform prior authorization programs and processes.

More broadly, the AMA also has engaged with the National Association of Insurance Commissioners and others to support notification of patients and physicians before a health insurance company or PBM may change a patient’s prescription. This situation often occurs as a PBM restricts a formulary during a patient’s plan year. In 2017, two of the nation’s two largest pharmacy benefit managers – Express Scripts and CVS/Caremark, which set the coverage for many health insurers – continue to aggressively remove medications from their formularies.

When health insurers or PBMs decide to exclude certain products, or increase the patients’ cost-sharing, patients are forced to switch to a new medication, which may or may not be as effective. And if the patient wishes to continue taking the medication that he or she used to stabilize a medical condition, the off-formulary cost may not be affordable – and it will not count towards the patient’s deductible. These types of forced-switching and increased patient cost-sharing are associated with declines in medication adherence, which in turn can lead to poorer patient health outcomes. In some cases, patients are forced to choose between necessary treatments and decisions such as expenses for food or shelter.

For physicians and patients, when a prescription for an opioid analgesic—or any other medication—is denied at the pharmacy counter, there may be multiple reasons. In some cases, as described above, the health insurance company or the PBM may be applying a hard edit associated with limits based on the CDC Guidelines. In other cases, it may be the pharmacy chain policy that
determines what the pharmacist may dispense. In these situations, the pharmacist is placed in the difficult position of having to inform the patient, and often, the physician, that the original prescription will not be filled. In other cases, also described above, the pharmacist may determine—per his or her lawful exercise of the pharmacist’s corresponding responsibility—that the prescription was not issued for a legitimate purpose in the usual course of professional practice.

In these situations, if the pharmacist communicates with the physician to determine how to proceed, this will take time away from the physician’s practice and the pharmacist’s ability to help more patients. The AMA supports physician-pharmacist interactions to ensure patient safety, but in some cases, the decision has been taken out of the pharmacist’s control—frustrating the physician, pharmacist and likely adversely affecting the patient. And even when the communication from the pharmacist to the physician is to resolve important questions, there still may be frustration due to having to take time away from patient care or return a call to the pharmacy, which may result in the physician being placed on hold for an extended period—further delaying and impeding patient care.

AMA POLICY

The AMA supports patients having access to the medications prescribed to them by their physician without interference into the practice of medicine (H-120.947, “Preserving Patients’ Ability to have legally Valid Prescriptions Filled”; D-35.981, “AMA Response to Pharmacy Intrusion Into Medical Practice”). For controlled substances, this policy must be tempered with the recognition that pharmacists share a corresponding responsibility that carries the same legal obligations and risks for failure to comply. In addition, AMA policy states opposition to “pharmacists being given the authority to initiate or modify prescription drug treatment except on a case by case basis at the specific direction of a physician” (H-160.928, “Drug Initiation or Modification by Pharmacists”). At the same time, the AMA recognizes that “cooperative relationships with law enforcement, regulatory agencies, pharmacists, and other professional groups” are necessary to identify situations where a person is attempting to obtain a prescription for fraudulent or otherwise illegal means (H-95.990, “Drug Abuse Related to Prescribing Practices”). Similarly, AMA policy “supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies” (H-95.932, “Increasing Availability of Naloxone”). It is worth noting that AMA advocacy, including development of model state legislation based on Policy H-95.932, has helped lead to enactment of naloxone access laws in all 50 states. AMA policy strongly supports “private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.” (H-95.932, “Increasing Availability of Naloxone”).

AMA policy is clear that health insurance carriers and PBMs must provide accurate information to patients at the time when plans are put forward for review by consumers. (H-125.979, “Private Health Insurance Formulary Transparency”). Furthermore, H-125.979 clearly states that “drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.” In addition, AMA policy supports “forbidding insurance carriers from making formulary deletions within the policy term.” In the event that an insurer or PBM does make a change, AMA policy calls for “notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.” As directed by our HOD, the AMA has drafted model state legislation to accomplish these goals, and the AMA strongly urges state medical societies to work with the AMA to introduce and enact the AMA model state legislation.
RECOMMENDATIONS

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

1. That our American Medical Association (AMA) urge the National Association of Boards of Pharmacy and Federation of State Medical Boards to support having national pharmacy chains, health insurance companies and PBMs testify at state-level public hearings by state/pharmacy boards, respectively, on whether their policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state law governing the practice of medicine and pharmacy, respectively. (Directive to Take Action)

2. That our AMA oppose specific dose or duration limits on pharmacologic therapy that are not supported by medical evidence and clinical practice. (New HOD Policy)

3. That our AMA reaffirm Policy H-95.990, “Drug Abuse Related to Prescribing Practices,” which supports cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups as necessary to identify situations where a person is attempting to obtain a prescription for fraudulent or otherwise illegal means. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-95.932, “Increasing Availability of Naloxone,” which supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


4 CDC Guideline For Prescribing Opioids For Chronic Pain, March 18, 2016. Available at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

5 Recommendation 5 of the CDC Guideline states: “When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.”

6 Recommendation 6 of the CDC Guideline states: “Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed (recommendation category).”


10 Centers for Disease Control & Prevention. Guideline for Prescribing Opioids for Chronic Pain. 2016. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm


REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-18

Subject: Medical Liability Coverage Through the Federal Tort Claims Act
(Resolution 214-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 214-A-17, “Medical Liability Coverage Through the Federal Tort Claims Act,” for report back at the 2018 Annual Meeting. This resolution was introduced by the New York Delegation and asked:

That our American Medical Association (AMA) seek legislation that would lead to malpractice insurance coverage through the Federal Tort Claims Act for all physicians who participate in Medicare and/or Medicaid and all federal insurance plans.

This report provides background on Federal Tort Claims Act (FTCA) medical liability protections and the potential implications of expanding FTCA protection to all federal health insurance plans.

FEDERAL TORT CLAIMS ACT

Congress originally enacted the FTCA in 1946 to provide immunity to federal government employees from tort liability when acting within the scope of their work. Under the FTCA, a patient of a federally employed physician who alleges acts of medical liability cannot sue the provider directly but must instead file the claim against the United States government. The federal government acts as the primary insurer and reviews and/or litigates claims via the U.S. Department of Health and Human Services (HHS) or the Department of Justice.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) extended FTCA protection to certain health professionals at qualifying free clinics, recognizing that these centers rely on volunteers to provide health services to poor and underserved patients. The Affordable Care Act expanded the FTCA liability coverage to the clinic’s board members, officers, paid health professional staff, and certain health professional contract employees.

Currently, the only private physicians who are covered by the FTCA must provide free care at qualified clinics. These private physicians are volunteers and cannot accept any payment from any third party. The liability protections provided by the FTCA are strong and have ensured that physicians and other practitioners are not deterred from volunteering their services at free clinics.

To be eligible for this comprehensive protection, private physicians must comply with explicit statutory requirements. Specifically, the clinic must be operated by a nonprofit entity, not accept reimbursement for providing health care services from any third-party payor (but may accept voluntary donations), and only impose charges on patients according to their ability to pay.

Similarly, the professional must be appropriately licensed or certified, may not receive...
compensation from the patients directly or from any third-party payor, and must provide patients
with written notification of the limited liability prior to providing services.

DISCUSSION

The existing medical liability system continues to drain health care resources that could be devoted
instead to improving quality of care and access for patients. Additionally, medical liability places
many physicians at unnecessary emotional, reputational, and financial risk. While expanding
FTCA coverage for all physicians who participate in federal health care programs may alleviate
high medical liability insurance premiums in certain states, such a broad expansion of the federal
government’s sovereign immunity would overall have large consequences across the practice of
medicine and could conflict with existing, long-standing, and successful AMA policy on medical
liability reform. Based on Medicare alone, Resolution 214-A-17 would impact almost 90 percent of
the practicing physicians in the United States.\(^1\) In addition, this protection would cover 37 cents of
every dollar of health expenditures in the United States.\(^2\)

Under Resolution 214-A-17, physicians would have no control over the direction of a medical
liability case involving a Medicare, Medicaid, or other federal health insurance patient. In a FTCA
case, the federal government represents the physician. Thus, physicians would have no choice as to
what attorney represents their medical liability case and no ability to decide whether a case goes to
trial or is settled, and, in turn, reported to the National Practitioner Data Bank (NPDB). Any court
judgments or settlements resulting from medical liability cases are reviewed by HHS’ Medical
Claims Review Panel and are reportable to the NPDB. The Panel is a peer review group of federal
employees that includes medical staff from HRSA and other HHS agencies and is responsible for:
(1) making a final determination as to whether the standard of care was met or not met; and (2)
identifying the clinician(s) who provided the treatment giving rise to the claim. If the Panel
determines the standard of care was not met, the named practitioner(s) will be reported to NPDB.

Currently, in the private sector, FTCA coverage only applies to health care providers who provide
free care at certain facilities, which is supported by AMA policy.\(^3\) Neither the health care provider
nor the institution can receive any third-party reimbursement for services rendered (e.g., public or
private health insurance). The congressional intent behind expanding the FTCA to these health care
providers was to increase the funds available to free clinics without increasing their budgets in
order to provide more free care to patients and to encourage volunteerism.\(^4\) In expanding FTCA
coverage to all federal health insurance patients, maintaining the requirement of providing free care
and not accepting any payment from any health insurance would be impractical for many
physicians. Alternatively, allowing for reimbursement from insurance and FTCA protection would
be a significant departure from previous federal policymakers’ intent in expanding access to free
care and to promote volunteerism. Moreover, such Medicare reimbursement may be decreased
because the physician fee schedule payment rate formula includes a Malpractice Resource Value
Unit which is intended to reflect the costs of liability insurance.

Resolution 214-A-17 may conflict with AMA policy on medical liability reform. Existing AMA
policy is focused on supporting initiatives implementing reforms based on California’s Medical
Injury Compensation Reform Act (MICRA)\(^5\) and additional reforms like certificate of merit and
expert witness requirements. Moreover, AMA policy expressly states that the AMA “actively
oppose” any federal initiatives that endanger state-based reform.\(^6\) Thus, if expanding the FTCA to
cover all physicians who participate in Medicare, Medicaid, and all federal health insurance plans
endangers state-based reform efforts, AMA policy would lead the AMA to actively oppose such a
federal initiative. In allowing for the federal government’s sovereign immunity to pass through to
virtually all private physicians, state-based reforms may be endangered. Given that the FTCA
requirements include both federal and state administrative and legal requirements, there is a substantial risk that applying the FTCA to any health care services that are federally funded could undermine comprehensive medical liability reforms at the state level. For example, any state procedural or evidentiary rules could be superseded by the Federal Rules of Civil Procedure and the Federal Rules of Evidence. Thus, a state evidentiary rule that makes a physician’s apology inadmissible in that state’s courts may not apply to a FTCA case and the apology could be introduced into evidence.

Even if states or individual physicians can opt-out of FTCA coverage, there could still be negative consequences. If a medical liability case involves an opted-out physician and a FTCA-covered physician, the federal government can bar the FTCA-covered physician from testifying to any aspect of the case. Finally, there is no evidence that reflects that physicians and patients would be better off under the universal application of the FTCA than under comprehensive state medical liability reforms like California’s MICRA or Texas’ similar law.

The Board has previously considered this issue. At the 2009 Annual Meeting, Resolution 226-A-09, “Revision of the Federal Tort Claims Act,” also introduced by the New York Delegation, was referred to the Board for decision. Similar to 214-A-17, the resolution asked our AMA to act on the proposal to extend the FTCA to any claim and/or health care service that is funded in whole or in part by federal funds (e.g., Medicare, Medicaid, etc.). The Board considered the resolution at its November 2009 meeting and decided, in lieu of adopting Resolution 226-A-09, to issue an informational report (Board Report 24-A-10, “Revision of Federal Tort Claims Act”) explaining the implications of a broad application of the FTCA. The Board concluded:

There is no evidence, however, that universal application of the FTCA will reduce the filing of meritless cases. In addition, expansion of the jurisdiction of the FTCA could undermine effective medical liability reform already in place in certain states, including California and Texas. An alternative to widespread application of the FTCA would be to assess the benefits of extending FTCA coverage through demonstrations at the state level or in particular settings such as federally qualified health centers.

Since this report, there remains no evidence that universal application of the FTCA will reduce the filing of meritless cases.

Furthermore, at the 2011 Annual Meeting, Resolution 204-A-11, “Sovereign Immunity for EMTALA-Related Care,” was referred to the Board for decision. This resolution called for FTCA coverage for EMTALA mandated care. Similar to Resolution 226-A-09, there was mixed testimony weighing the potential benefits of FTCA coverage against the potential negative effects for physicians, including loss of control over settlement decisions and increased NPDB reporting. The Board considered Resolution 204-A-11 at its November 2011 meeting and decided to amend policy D-130.971, “The Future of Emergency and Trauma Care,” by adding a statement that our AMA will “support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care.” Since this decision, there have been no demonstration programs implemented.

The Board believes that the AMA, along with the state and specialty medical associations, should continue to pursue both traditional and innovative medical liability reforms to strike a reasonable balance between the needs of patients who have been harmed and the needs of millions of Americans who need affordable, accessible medical care. Traditional reform includes efforts at both the state and federal levels to enact or maintain reasonable limits on subjective non-economic
damages. Innovative reforms include concepts like health courts, early disclosure and compensation models, expert witness guidelines, and affidavits of merit.

Given the lack of evidence that the application of the FTCA will benefit physicians, the Board concludes that Resolution 214-A-17 should not be adopted. If an FTCA coverage demonstration program were to occur that could show that FTCA coverage would benefit physicians, current AMA policy would support such a demonstration program as an innovative medical liability reform.

RECOMMENDATION

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

Fiscal Note: None.

REFERENCES


2 CMS, National Health Expenditures Accounts (2016). Total national health expenditures (which includes out of pocket expenses) for 2016 totaled $3,337,348,000,000. Resolution 214-A-17 calls for FTCA protection under Medicare, Medicaid, and other federal health insurance expenditures. We interpret “other federal health insurance” to include CHIP. We did not include the Federal Employees Health Benefits program because it is considered private insurance and did not include Tricare or Champva because the majority of the physicians providing care receive FTCA protection as federal employees. Medicare, Medicaid, and CHIP health expenditures for 2016 totaled $1,254,526,000,000.


5 The MICRA model includes a limitation of $250,000 on non-economic damages, mandatory offset of collateral sources of plaintiff compensation, decreasing sliding scale regulation of attorney contingency fees, and periodic payment for future awards of damages.


7 45 C.F.R. Part 2.

APPENDIX – CURRENT AMA POLICY

Policy D-435.969, “Liability Related to Referrals from Free Clinics”
That our American Medical Association will work with interested medical associations to enact state legislation that provides medical liability immunity, similar to the protections granted under the Federal Tort Claims Act (FTCA), to physicians who provide charity care in hospitals, offices, clinics or other health care settings to patients referred from free clinics.

Policy H-160.940, “Free Clinic Support”
Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions.

Policy H-435.978, “Federal Medical Liability Reform”
Our AMA: (1) supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of $250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages; (2) reaffirms its support for the additional reforms identified in Report L (A-89) as appropriate for a federal reform vehicle. These are: (a) a certificate of merit requirement as a prerequisite to filing medical liability cases; and (b) basic medical expert witness criteria; (3) supports for any federal initiative incorporating provisions of this type would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. Federal preemptive legislation that endangers state-based reform will be actively opposed. Federal initiatives incorporating extended or ill-advised regulation of the practice of medicine also will not be supported. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.

1. It is the policy of the AMA that effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. The AMA's MICRA-based federal tort reform provisions include: (a) a $250,000 ceiling on non-economic damages, (b) the offset of collateral sources of plaintiff compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d) periodic payment of future awards of damages, and (e) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth.
2. Our AMA also supports federal reform to achieve: (a) a certificate of merit requirement as a prerequisite to filing medical liability cases; (b) statutory criteria that outline expert witness qualifications; and (c) demonstration projects to implement potentially effective alternative dispute resolution (ADR) mechanisms.
3. Our AMA supports medical product liability reform, applicable to the producers of pharmaceuticals and medical devices, as an important state and federal legislative reform objective.
4. Any health system reform proposal that fails to include MICRA type reform, or an alternative model proven to be as effective in a state, will not be successful in containing costs, providing access to health care services, and promoting the quality and safety of health care services. Under no circumstances would support for federal legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states. Federal preemptive legislation that endangers effective state-based reform will be actively opposed.

Policy D435.992, “Liability Reform”
Our AMA: (1) in concert with a coalition for civil liability reform, shall develop a broad-based and sustained grassroots member mobilization campaign to communicate its call for immediate
legislative relief from the current tort system to our congressional representatives and senators; (2) will work for passage of significant legislation in both houses of the US Congress on liability reform in this congressional year; and (3) will work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process.

Policy D-435.974, “Health System and Litigation Reform”
Our AMA will (1) press vigorously and creatively for inclusion of effective medical litigation reforms as part of the comprehensive federal health system/insurance reform debate now underway in Washington, DC; and (2) consider and, as necessary, negotiate with federal policymakers on a wide range of litigation reform policy options to gain inclusion of a remedy in the health system reform package. These options might include traditional tort reforms, recovery limitations similar to those of the Veterans Administration (VA) system, demonstration/pilot programs on alternate dispute resolution systems such as the VA model and health courts, and/or other effective options to preserve patient access to care.
INTRODUCTION

At the 2017 Interim Meeting Resolution 218-I-17, “Health Information Technology Principles,” was referred by the House of Delegates. Resolution 218-I-17, introduced by the Organized Medical Staff Section, asks the American Medical Association (AMA) to adopt and promote the development of effective electronic health records (EHR) in accordance with the following health information technology principles:

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

This resolution was referred for report back at the 2018 Annual Meeting.

BACKGROUND

Health information technology (HIT), specifically EHRs, has been plagued with numerous usability, flexibility, and security issues that have negatively impacted the end-user experience. These issues have contributed to high levels of physician burnout and a diminished patient-physician relationship. Physicians have been vocal about their frustration with these systems and their lack of input into the decision process when purchasing and implementing them in practice. To successfully implement and gain widespread adoption of HIT, physician input and buy-in is crucial.
Data issues are commonly cited as a point of dissatisfaction. Physicians are often unable to find the data they need when they need it. It is also not delivered in a way that fits within their workflow or documentation procedures. Another common complaint is that their documentation practices are established in response to external drivers versus what is truly necessary and important to the care of the patient.2

Lack of interoperability is also a source of discontent for many physicians. This is a multifactorial, complex issue that involves cooperation and dedication from many key stakeholders including government, vendors, and health systems. Cost, competing priorities, and misaligned incentives contribute to barriers in achieving full interoperability across health care, negatively impacting the front-line of care.3

The AMA has been successful in making progress toward improving and advancing EHRs and HIT through advocating for policy and collaborating with stakeholders. This resolution proposes further allegiance to this work through formal adoption of clear and concise principles for technology-enabled solutions to ensure physician input is included in the development and use of HIT, specifically EHRs, to improve both the physician and patient experiences.

AMA POLICY

The AMA is committed to working with federal and state agencies, policymakers, and other relevant stakeholders to improve EHRs and advance HIT. The AMA encourages physician involvement in defining, evaluating, and implementing EHRs for improved usability, access, and security (Policy H-480.971, “The Computer-Based Patient Record”).

The AMA is steadfast in its efforts to improve EHR usability and enhance access to data for both physicians and patients. The AMA works with the Office of the National Coordinator for Health Information Technology (ONC) and EHR vendors to support interconnectivity and interoperability enabling the efficient and cost effective use and sharing of data across all care settings (Policy D-487.995, “National Health Information Technology”). The AMA also continues to support and encourage Congress to eliminate unnecessary data blocking to improve and expand the exchange of data (Policy D-478.972, “EHR Interoperability”).

The AMA is committed to actively engaging with federal and state agencies, EHR vendors, and other stakeholder groups in their efforts to reduce the cost burdens often associated with EHRs. The AMA promotes EHR vendor cost transparency around implementation, maintenance, and interface production (Policy D-478.973, “Principles of Hospital Sponsored Electronic Health Records”). The AMA advocates for flexibility related to the adoption and use of HIT across versions and editions as to not cause disproportionate financial burden or penalization to physicians and practices (Policy D-478.996, “Information Technology Standards and Costs”). Additionally, the AMA supports legislation that provides positive incentives for physicians to acquire HIT (Policy D-478.994, “Health Information Technology”).

DISCUSSION

Lack of physician voice in the development, evaluation, and implementation of HIT has contributed to high rates of physician dissatisfaction with HIT, specifically EHRs. Dissatisfaction among EHR end-users has contributed to physician burnout, a diminished patient-physician relationship, and unrealized cost savings.5
This resolution proposes eight HIT principles for the development of effective EHRs. The AMA released eight EHR usability priorities in 2014, many of which are closely aligned with the principles proposed in Resolution 218-I-17. These priorities were developed by the AMA Advisory Committee on EHR Physician Usability. Members included former president of the AMA Steven Stack, MD, chief medical information officers, practicing physicians, and medical professors. The priorities identified in 2014 by the AMA’s Advisory Committee on EHR Physician Usability are as follows:

1. Enhance physicians’ ability to provide high-quality patient care.
2. Support team-based care.
4. Offer product modularity and configurability.
5. Reduce cognitive workload.
6. Promote data liquidity.
7. Facilitate digital and mobile patient engagement.
8. Expedit user input into product design and post-implementation feedback.

These priorities outline and support the need for better usability, interoperability, and access to data for both physicians and patients. In addition, they reaffirm the importance of considering patient care and physician input in the build and implementation related to EHRs. The AMA works to advance these goals through key stakeholder engagement (i.e., EHR vendors, health systems, and researchers), advocacy, and education. The AMA actively promotes these priorities and several vendors, including athenahealth and MEDITECH, have publicly acknowledged how their products align with these priorities.

Furthermore, these priorities have guided the AMA in its advocacy efforts to adopt and promote the development of effective HIT. For example, these efforts are demonstrated in statutory and regulatory changes made by the federal government:

**21st Century Cures Act**
- Creating information blocking provisions against EHR vendors including an up to $1,000,000 civil monetary penalty;
- Requiring Certified EHR IT (CEHRT) to incorporate application programing interfaces (API);
- Requiring real-world testing of EHRs;
- Prohibiting restrictions on user communications about EHR usability, interoperability, security, and developer business practices;
- Requiring EHRs to exchange data with clinician-led clinical registries;
- Prompting patient access to their longitudinal health record; and
- Requiring the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of EHRs.

**ONC Enhanced Oversight and Accountability Rule**
- Increasing federal oversight of EHR functionality post-certification.
- Holding health IT developers accountable to certification non-conformities including allowing for ONC corrective action plans and CEHRT certification suspension and/or termination.

**ONC 2015 Edition Health IT Certification**
- Requiring HIT vendors to disclose fees for EHR functions, including connecting to health information exchanges (HIE) and clinical registries;
• Increasing user-centered design (UCD), i.e., usability requirements, in CEHRT development; and
• Requiring HIT developers to use and test against advanced interoperability standards (which improves data liquidity).

The AMA’s robust research agenda drives its pursuit of a strong evidence base to inform industry wide HIT innovation and the improvement of EHR development and implementation. The AMA in 2013 partnered with the RAND Corporation to study factors that affect physician professional satisfaction, which resulted in quantitative and qualitative evidence that EHRs are a major source of dissatisfaction for physicians. The AMA led a comprehensive time-motion study that demonstrated for every one hour of face-to-face time with patients, physicians spend nearly an additional two hours doing EHR and administrative deskwork. The AMA has also published multiple journal articles on the topic of EHRs and their contributions to physician dissatisfaction, burnout, and undue administrative burden. In addition to this established work, the AMA is currently collaborating with multiple partners to execute research planned for publication in 2018. These efforts include an observational study aimed at tracking physician actions during EHR use; an evaluation of barriers and facilitators to adoption of digital health solutions; and research aimed at identifying opportunities to improve the usability and safety of EHRs. The AMA will continue to pursue research to help stakeholders, including physicians, payers, regulators, health system leadership, and EHR vendors, make informed improvements to the EHR user experience.

In collaboration with the American Heart Association, HIMSS, and DHX Group, the AMA founded Xcertia in 2016. This collaboration is dedicated to developing guidelines that foster safe, effective, and reputable health technologies. Through engagement from a diverse group of industry stakeholders, Xcertia aims to reduce burden on providers/health care sponsors, give consumers confidence, and help technology developers bring better solutions to the market. Xcertia has already published preliminary guidelines covering four major areas—operability, privacy, security, and clinical content. As HIT solutions continue to evolve, the guidelines provided by Xcertia will be further developed to align with and be applicable to additional forms of HIT, resulting in an inclusive set of guiding principles.

The AMA has established partnerships with the SMART Initiative, AmericanEHR Partners, and Medstar Health’s National Center for Human Factors in Healthcare to help foster innovative HIT design and transparent testing solutions which will ensure EHRs are designed and implemented with physicians and patients in mind. In addition, the AMA actively participates in The Sequoia Project, Carequality, and the CARIN Alliance, all aimed at enhancing interoperability in health care. The AMA is also working to address specific cost drivers, such as connecting to clinical data registries and prohibitive fees that amount to data blocking. The AMA’s Physician Innovation Network is also connecting physicians and health tech entrepreneurs to ensure that the physician voice is integrated into health care technology solutions coming to market.

The AMA is the founder and sole shareholder of Health2047, a Silicon Valley-based innovation enterprise focused on developing and commercializing solutions in the areas of data liquidity, chronic care, productivity, and payments to significantly change U.S. healthcare at the system level. Building on initial work performed within Health2047, including a collaboration with Celgene Corporation, Health2047 created Akiri Switch, a newly spun-off company that will commercialize a blockchain-based private network that enables secure permissions-based sharing of health data among patients, physicians, providers, payers, pharma and other healthcare enterprises. Through this work the AMA further demonstrates its commitment to seeking out and developing HIT solutions for the future and long-term sustainability of health care.
The AMA’s eight EHR usability priorities provide clear and concise requirements for the development of effective EHRs, very similar to this resolution’s proposed principles for the development of effective EHRs. Principles one through five proposed in Resolution 218-I-17 closely align with the direction provided in these established priorities.

The sixth proposed principle states that in the development of effective EHRs “there should be no institutional or administrative barriers between physicians and their patients’ health data.” Administrative and institutional barriers most often stem from decisions made at the organizational level, not in the development of the EHR system. Therefore, it is not recommended that AMA adopt a principle that may misrepresent the extent to which EHR developers influence or control barriers that exist between users and their administrations or institutions.

The proposed principle seven states “information technology should promote the elimination of health care disparities.” Numbers one, three and seven of the eight established EHR usability priorities are “enhance physicians’ ability to provide high-quality patient care; promote care coordination; and facilitate digital and mobile patient engagement.” These priorities, if followed in the development of EHRs and other HIT, will enable the technology to support access to care, facilitate better patient interactions, and ultimately help address health care disparities. Since the proposed principle offers direction similarly provided in the priorities, it is not recommended to adopt this principle as separate policy.

Principle eight of this resolution asks the AMA to provide data that will convince payers to increase payment rates, essentially asking the AMA to take a position that payers are responsible for reimbursing physicians for the costs associated with implementing IT systems. Given the many facets of HIT implementation, systematic compilation of this data would be difficult given the complex state of payment models, ongoing changes with reimbursement, and variations in practice types and their unique IT needs and related costs. Additionally, the AMA previously elected to not adopt a similar resolution (813-I-16), instead resolving to focus on encouraging vendors and payers to actively work toward better, more user-friendly and cost-effective solutions that do not overburden physicians and practices.

As evidenced by the preceding discussion, the AMA currently dedicates significant resources to improving usability, enhancing interoperability, and bringing value into EHRs and HIT. The AMA’s already established eight EHR usability priorities provide clear and concise requirements for the development of effective EHRs. In using these priorities, AMA has successfully advocated for the adoption and promotion of the development of effective EHRs as can be seen in the 21st Century Cures Act, ONC Enhanced Oversight and Accountability Rule, ONC 2015 Edition Health IT Certification, and in many other rules and guidance documents from the Department of Health and Human Services. Additionally, Xcertia is currently developing broader guidelines for health care technologies in the areas of content, usability, privacy, security, and operability, inclusive of many key stakeholders across the health technology landscape. Through its current work, the AMA recognizes the value of established standards and guiding principles for many aspects of health care. The AMA will continue its efforts to further develop research, content and guidance for physicians, and will regularly ensure those resources are relevant, timely, and easily accessible.
RECOMMENDATION

The Board of Trustees recommends that our American Medical Association adopt the following in lieu of Resolution 218-I-17, and the remainder of this report be filed:

1. That the following policies be reaffirmed:
   - H-480.971, “The Computer-Based Patient Record”
   - D-478.972, “EHR Interoperability”
   - D-478.973, “Principles for Hospital Sponsored Electronic Health Records”
   - D-478.994, “Health Information Technology”
   - D-478.995, “National Health Information Technology”
   - D-478.996, “Information Technology Standards and Costs” (Reaffirm HOD Policy)

2. That our AMA promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
   1. Enhance physicians’ ability to provide high quality patient care;
   2. Support team-based care;
   3. Promote care coordination;
   4. Offer product modularity and configurability;
   5. Reduce cognitive workload;
   6. Promote data liquidity;
   7. Facilitate digital and mobile patient engagement; and
   8. Expedite user input into product design and post-implementation feedback. (New HOD Policy)

3. That our AMA utilize HIT principles to:
   1. Work with vendors to foster the development of usable EHRs;
   2. Advocate to federal and state policymakers to develop effective HIT policy;
   3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
   4. Partner with researchers to advance our understanding of HIT usability; and
   5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care. (New HOD Policy)

Fiscal note: Modest – Between $1,000 - $5,000
REFERENCES

EXECUTIVE SUMMARY

Interest in augmented intelligence (AI) and its potential to dramatically impact medicine is growing rapidly among Congress, federal agencies, and other health care stakeholders. As a leader in American medicine, our American Medical Association (AMA) is uniquely positioned to ensure that the evolution of AI in medicine benefits patients, physicians, and the health care community. However, the AMA currently has no policy specifically on AI. This report proposes baseline policy to guide AMA’s engagement with a broad cross-section of stakeholders and policymakers to ensure that the perspective of physicians in various practice settings informs and influences the dialogue as this technology develops.

Ensuring the appropriate implementation of AI in health care will require that stakeholders forthrightly address challenges in the design, evaluation, implementation, and oversight of AI systems. Through its strategic partnerships and collaborations, the AMA has the capacity to help set priorities for health care AI; integrate the perspective of practicing physicians into the design, validation, and implementation of high-quality, clinically valuable health care AI; and promote greater understanding of the promise and limitations of AI across the health care community. A strong tradition of advocacy well positions our AMA to explore the legal implications of the emerging technologies of AI in health care and advocate effectively for appropriate professional and governmental oversight for safe, effective, equitable use of and access to health care AI.
Subject: Augmented Intelligence (AI) in Health Care

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

A component of the American Medical Association’s (AMA) strategic work in 2018 and beyond is to provide the physician perspective across health care technology sectors by promoting improved usability of and productive access to data used in medical decision making as well as respect for the patient-physician relationship. As our AMA implements this component of its strategic plan, the Board of Trustees has observed a rapidly growing interest in augmented intelligence (AI) technology in health care. In 2018, the AMA Council on Long Range Planning and Development (CLRPD) provided the Board with a primer on the history, definitions and components, and the status of AI in health care that offered a high-level look at this rapidly evolving area and its potential to dramatically impact medicine. The AMA Council on Legislation (COL) and CLRPD have observed increased interest in AI by Congress, federal agencies, and other health care stakeholders. To form a clearer understanding of the expected impact of AI technologies for patients and physicians, as well as key stakeholders who are influencing legislation and regulation in this area, over the past 18 months the COL has met with physician experts immersed in the development and clinical integration of various health care AI technologies.

Both Councils have highlighted to the Board that current AMA policy does not specifically address AI. The Board determined that this gap in policy puts our AMA at a strategic disadvantage in the public debate on health care AI, and therefore strongly believes it is important for our AMA to adopt a base-level of policy on health care AI to guide AMA’s engagement with a broad cross-section of stakeholders and policymakers in order to ensure that the perspective of physicians in various practice settings informs and influences the dialogue as this technology develops.

WHAT IS HEALTH CARE AI?

Computational methods and techniques for data analysis have been evolving for decades [1,2]. A number of these methods have come to be known collectively as “artificial intelligence.” Artificial intelligence constitutes a host of computational methods that produce systems that perform tasks normally requiring human intelligence. These computational methods include, but are not limited to, machine image recognition, natural language processing, and machine learning. However, in health care a more appropriate term is “augmented intelligence,” reflecting the enhanced capabilities of human clinical decision making when coupled with these computational methods and systems.

In December 2017, Senators Maria Cantwell (D-WA), Todd C. Young (R-IN), and Edward Markey (D-MA) and U.S. Representatives John Delaney (D-MD) and Pete Olson (R-TX) introduced S. 2217/H.R. 4625, “Fundamentally Understanding the Usability and Realistic Evolution (FUTURE) of Artificial Intelligence Act of 2017.” The legislation defines “general AI” as computational methods that produce systems that exhibit intelligent behavior at least as advanced as a human across the range of cognitive, emotional, and social behaviors. In contrast, the bill
defines the term “narrow AI” as computational methods that address specific application areas, such as playing strategic games, language translation, self-driving vehicles, and image recognition. Thus, these AI methods and tools for the foreseeable future are better characterized as narrow AI that augments human intelligence (augmented intelligence).

At a February 2018 U.S. House of Representatives Government Oversight Committee Subcommittee on Information Technology hearing, three national experts testified that general AI is decades away and agreed AI is best characterized as augmented intelligence. Consistent with the foregoing, in response to a 2016 Request for Information on Artificial Intelligence issued by the White House Office of Science and Technology Policy, IBM stated that it is “guided by the term ‘augmented intelligence’ rather than ‘artificial intelligence’.” IBM noted further, “It is the critical difference between systems that enhance and scale human expertise rather than those that attempt to replicate all of human intelligence.” [3]

Software algorithms developed using these evolving methods and techniques, coupled with proliferating sources of data (datasets) pertinent to health and medicine, offer the promise of new and more powerful ways to augment human intelligence and expertise in health care.

The American College of Radiology (ACR), which has been at the leading edge of health care AI, addressed its promise in comments to the White House Office of Science and Technology Policy in 2016:

AI could offer various benefits to medical imaging in the future, including augmenting the capabilities of radiologists to enhance their efficiency and accuracy, as well as reducing costs by improving the appropriateness and cost-effectiveness of medical imaging utilization. The use of AI and machine learning in health care in general could be best applied to the areas of precision medicine, predictive analytics, and outcomes assessments. AI can streamline health care workflow and improve triage of patients (especially in acute care settings), reduce clinician fatigue, and increase the efficiency and efficacy of training. Moreover, shortages of medical experts to meet the needs of vulnerable and underserved populations in domestic and international settings could potentially be relieved, in part, by AI [4].

Prime AI applications include clinical decision support, patient monitoring and coaching, automated devices to assist in surgery or patient care, and management of health care systems [5]. AI in health care holds out the prospect of improving physicians’ ability to establish prognosis [6], as well as the accuracy and speed of diagnosis [6,7,8], enabling population-level insights to directly inform the care of individual patients [9], and predicting patient response to interventions [10]. The number of empirical studies of AI applications in medicine is growing rapidly [2].

WHAT’S NEXT IN HEALTH CARE AI?

Commercial entities, including IBM, Google, and others, are driving rapid evolution in AI across the board. In health care, the next three to five years will be marked by efforts to scale AI options involving patient-centered wearables that support clinical care, improved tools for diagnosis and physician training, and health system initiatives to improve patient care and clinical decision support [11]. The following are early examples of such efforts.

Wearable AI

Wearable monitoring devices that can transmit patient data are evolving rapidly. For example, one company has developed the Cardiogram application which is designed to work with the built-in
infrared heart rate sensor of the Apple Watch to detect hypertension and sleep apnea. In a study carried out with the University of California–San Francisco that involved over 6,000 patients, the application and its machine learning system, DeepHeart, was able to detect hypertension and sleep apnea with 82 percent and 90 percent accuracy, respectively [12]. Rapid innovation is expected on this front propelled by coverage of payers, including Medicare, of remote patient monitoring and management.

New Tools for Diagnosis and Physician Training

The utilization of machine learning algorithms to enhance clinical decision making is increasing, but emerging systems take such support a step further. For example, the Human Diagnosis Project (Human Dx), organized as a tandem 501(c)(3) nonprofit and public benefit corporation, and created with and led by the medical community, allows attending physicians to ask for assistance on difficult medical cases from an online community of physicians all over the world. Responses from the medical community are combined with help from machine learning to create a synthesized collective assessment for each case. This collective insight is designed to augment clinical decision making with machine intelligence, providing useful information to physicians and patients who may not otherwise have access to specialist expertise. Human Dx also provides a platform for medical education through its Global Morning Report teaching cases. Today, residents from over 40 percent of U.S. internal medicine residency programs have access to these cases. Human Dx vets the quality of responses by comparing how physicians solve reference training cases in order to calculate a quantitative measure of reasoning called Clinical Quotient, which is now being vetted in conjunction with the Johns Hopkins School of Medicine.

Health Systems and Data Analytics

Applying AI to health system data to improve care is another area of rapid evolution. The University of Pittsburgh Medical Center (UPMC) has launched a system-wide effort to reduce hospital readmissions and enhance clinical decision making while a patient is receiving care. UPMC has applied machine learning to claims data to predict a patient’s risk of readmission before the patient arrives. A second algorithm uses laboratory and clinical metrics extracted from clinical records to update the risk prediction every 15 minutes over the course of the patient’s admission. Before discharge, if the risk prediction’s two models are in conflict, UPMC uses unsupervised machine learning to come up with a set of rules that dictate which model takes precedence to inform clinician discharge decisions [13].

These three relatively nascent efforts are designed to scale, but will require significant additional research and real world testing. However, they illustrate the types of initiatives beyond condition-specific efforts to enhance clinical decision support that could produce significant improvements in health care. Notably, these efforts have active engagement and support of clinicians and seek to address medical challenges and problems identified by clinicians.

FEDERAL ENGAGEMENT WITH AI

AI has surfaced as a public policy issue at the federal level in a relatively short period of time. In 2016, the White House Office of Science and Technology hosted several public meetings on a range of public policy issues addressing AI along with a public request for information regarding potential policy directions. In Congress, the U.S. Senate Commerce Committee held a hearing titled “The Dawn of Artificial Intelligence” at which the Department Chair for Genomic Medicine at MD Anderson Cancer Center highlighted the clinical applications of AI and discussed policy implications.
Shortly thereafter, the 21st Century Cures Act was passed by Congress and became law in December 2016. The Act included provisions modifying the U.S. Food and Drug Administration’s (FDA) oversight of software as a medical device, which has implications for a number of current AI computational methods. The FDA is now actively evaluating whether a new oversight framework is needed for software as a medical device, a precursor to future oversight models.

The bipartisan “FUTURE of Artificial Intelligence Act,” introduced in December 2017, provides for the establishment of a Federal Advisory Committee on the Development and Implementation of Artificial Intelligence. The legislation, if passed, would be the first effort at the federal level to provide a forum for consideration of AI public policy. In 2018, additional legislation has been introduced, and additional congressional hearings held on AI generally, with health care applications receiving particular attention.

ACHIEVING THE PROMISE OF AI IN HEALTH CARE

Fulfilling the promise that “combining machine learning software with the best human clinician ‘hardware’ will permit delivery of care that outperforms what either can do alone” [14] will require that stakeholders forthrightly address challenges in the design, evaluation, implementation, and oversight of AI systems in health care. In the first instance, stakeholders across the board, not the least among them patients and physicians, must hold realistic expectations for the roles AI tools can and cannot play. Machine learning is only one of the AI computational methods and raises particularly thorny challenges. However, many of the public policy issues (including transparency and intellectual property) and clinical issues that will need to be addressed apply to other AI computational methods that are more common currently, such as natural language processing.

Designing and Evaluating Health Care AI

There is a popular tendency to see AI as, at best, a form of neutral, “objective” decision making, a pristine mathematical process that takes only “the facts” into account, independent of human judgment [15,16,17]. The statistical process of AI specifically seeks to derive a rule or procedure from a body of data that explains that data or is able to predict future data [18]. An AI derived algorithm “is only as good as the data it works with” [19,20]. The data sets on which AI algorithms are trained are created by human agents and are imperfect.

The research, patient care, and insurance records available as training data sets for health care AI can be highly variable, reflecting the different purposes for and processes by which they were created [1,21]. Clinical trials systematically include or exclude participants with certain characteristics; patient charts and insurance records capture information only from those individuals who have access to the health care system and rarely contain information about exposure to environmental toxins. Different data sets focus on different kinds of information to the exclusion of other possible data points, and records capture and preserve information with varying degrees of accuracy.

One of the most significant implications for end users of AI systems is that these systems sets can, invisibly and unintentionally, “reproduce and normalize” the biases of their training data sets [16,17]. In health care, the result can be models that “reflect the conditions only of the fortunate” and yield “an aggregate understanding of health and illness that fundamentally excludes the marginalized” [21] in a way that risks exacerbating existing health disparities. Minority populations can be disadvantaged in the context of AI systems in a second way as well in that “by definition, there is proportionately less data available about minority predictions,” while the accuracy of decision making, a proxy for fairness, will be higher for majority groups [17]. Addressing fairness...
is essential, even if doing so may be costly for developers when it requires them to seek more complex decision rules [17].

Design issues also encompass how a model is evaluated, as well as relationships between the dataset used to train an algorithm and the dataset used to evaluate the algorithm. In the first instance, evaluation criteria must be clinically relevant and evaluation should be representative of how the algorithm will be applied in practice [22]. For example, evaluating a model to predict risk of hospital-acquired infection over the entire course of a patient’s admission more accurately predicts how the model would be used and would perform in practice [22]. For predictive models, developers must evaluate “how far in advance the algorithm identifies positive cases.” [22] From a clinician’s perspective, the critical concern is “predicting events early enough for a relevant intervention to influence care decisions and outcomes.” [14] Ensuring that all examples in the training dataset are earlier in time than all examples in the evaluation set helps avoid misleading results by limiting the possibility that training data could otherwise reflect structural changes in hospital population, clinical protocols, electronic health record (EHR) systems, or other factors that occurred over time [22].

Developers also have a responsibility to ensure that their work is transparent and can be reproduced by others [23,24]. Proposed guidelines for essential components of publications reporting development of predictive machine-learning algorithms include not only rationale and objectives, but, importantly, the setting, prediction problem, relevant data, and a description of the building of the predictive model [23]. Authors should also provide information about the final model and its performance, and discuss the clinical implications of the work, its limitations, and unexpected results. Scholars have further recommended creating open repositories for long-term storage, archiving, and access to datasets and code to enable replication of published findings [24].

Furthermore, the AMA’s work in the area of EHRs reveals that to be useful and accepted in practice, AI systems need to be developed and evaluated in keeping with best practices in user-centered design [25]. The focus must be on users’ needs and usability should be tested by participants who are demographically representative of end users [26].

**Health Care AI and Patient Privacy**

Commitment to protecting the confidentiality of patient information is central to medicine’s professional ethos. In this respect, AI poses a significant challenge where traditional strategies of notification and consent are no longer adequate [18]. Nor are anonymization, deletion of data, or distinguishing metadata sufficiently robust protections in the context of massive complex data sets [18,20] when machine-learning algorithms can identify a record “easily and robustly” from as few as three data points [20].

The ease of re-identification means that, in important respects, traditional expectations for health care privacy are simply no longer attainable. This significantly raises the bar on the task of ensuring the security and integrity of data. Among proposed technical solutions to the dilemma of privacy in large data sets are “blockchain-style” technology to secure data and track access or data auditing systems that allow secure verification of the contents of large data structures, such as those being explored by DeepMind Health in the UK [1]. Researchers at the University of Pennsylvania have explored the creation of publicly sharable simulated datasets that limit possible re-identification as another approach to protecting data privacy [27]. The recent revelation that the data mining firm Cambridge Analytica siphoned private data from 50 million Facebook users to target them for political campaigns raises confidentiality and privacy questions across the spectrum of digital platforms that collect and curate data. While this report establishes policy that
underscores the necessity to safeguard individuals’ privacy interests and preserve the security and
integrity of personal information, the Board recognizes the importance of this issue and will
continue to assess our policy as our AMA engages in the public debate and discourse on protecting
patient information.

Implementing Health Care AI

The AMA’s ongoing engagement with digital health offers insights for understanding, from
physicians’ perspectives, what is at stake in integrating AI systems into the delivery of health care.
The organization’s recent survey of 1,300 physicians about barriers to adoption of digital health
technologies suggests that physicians are most receptive to digital health tools they believe can be
integrated smoothly into their current practice, will improve care, and will enhance patient-
physician relationships [28]. Coverage for liability, assurance that data privacy is protected, linkage
to their EHR, and billing/reimbursement are key considerations.

Earlier AMA research into physician professional satisfaction found that frustrations with EHRs,
especially usability issues, were a major source of dissatisfaction in physicians’ professional lives
[29]. The findings led the AMA to identify priorities for ensuring usability in EHR systems,
including, among other considerations, ensuring that EHRs are designed to meet the cognitive and
workflow needs of physicians, that they support team-based care, promote coordination of care,
focus on reducing cognitive workload instead of focusing simply on data collection, and
incorporate end user feedback into designing and improving EHR systems [25].

AMA policies addressing the use of telemedicine similarly stress the importance of minimizing
disruptive effects on patient-physician interactions, ensuring that technologies promote quality of
care and safety, and, importantly, establishing mechanisms to monitor the impact of an innovation
both to identify and address adverse consequences and to identify and encourage dissemination of
outcomes [30,31].

To reap the benefits for patient care, physicians must have the skills to work comfortably with
health care AI. Just as working effectively with EHRs is now part of training for medical students
and residents [32], educating physicians to work effectively with AI systems, or more narrowly, the
AI algorithms that can inform clinical care decisions, will be critical to the future of AI in health
care.

Physicians need to understand AI methods and systems sufficiently to be able to trust an
algorithm’s predictions—or know how to assess the trustworthiness and value of an algorithm—as
a foundation for clinical recommendations. The challenge may be more easily met with advances in
“explainable AI,” that is, algorithms that can “explain” to users why a particular prediction is made
[33,34]. Technology to predict the risk of 30-day readmission for cardiac patients being tested by
Boston-based Partners Connected Health provides clinicians with a readmission prediction score
and identifies the top factors contributing to that score, providing information that is actionable for
clinicians [35].

A LEADERSHIP ROLE FOR AMA

To realize its potential to support improved patient care and health outcomes and enhance
physician professional satisfaction, the health care AI enterprise should be informed and guided by
the expertise, experience, and leadership of physicians and organized medicine in developing and
implementing these tools. Physicians are well positioned to advocate for health care AI solutions
that support healthier lifestyles and reduce disease burden, improve access to care, enhance
diagnostic accuracy, inform individually tailored treatment plans, and improve patient self-
management, adherence, and health outcomes. Physicians are likewise well placed to apply their
experience to drive improved design and implementation of health care AI that will strengthen
clinicians’ relationships with patients; enhance communication among the health care team and
between team members, patients, and family members; simplify the coordination of care; minimize
administrative burdens; and help the health care team to better deliver care to those patients and
populations in greatest need.

As a leading voice in American health care, the AMA is uniquely positioned to help ensure that
emerging technologies best serve the nation’s patients and physicians. In addition to the work of
COL and CLRPD, at the 2017 Interim Meeting all seven AMA councils met jointly with experts
from IBM Watson and HumanDx to discuss issues in health care AI. Likewise, the AMA’s
ongoing engagement with key stakeholders from across the spectrum of clinical care, health care
administration, implementation science, and AI product development enables the organization to
play a distinctive role in contributing to the overarching vision for health care AI in the U.S.

Through its strategic partnerships and collaborations, the AMA has the capacity to offer the insight
that is critical to the development of clinically sound AI systems that will enhance the quality of
care and sustain the integrity of patient-physician relationships. The AMA’s strong tradition of
advocacy positions the organization to promote meaningful oversight of AI as it is integrated into
clinical practice.

CONCLUSION

Patients, physicians, and the health care system in the U.S. face enormous challenges in the
combined impact of a rapidly aging population, a relative decline in the working population that
reduces revenue essential for safety net programs [36], and persistent high costs of care that will
strain the nation’s ability to support affordable, accessible, high quality care. With the engagement
of physicians to identify needs and set priorities for design, development, and implementation,
health care AI can offer a transformative set of tools to help patients, physicians, and the nation
face these looming challenges. Given the number of stakeholders and policymakers involved in the
evolution of AI in health care, it is important that our AMA not only adopt a base level of policy to
guide our engagement, but equally continue to refine our policy as an organization to ensure that
the perspective of physicians in various practice settings informs and influences the dialogue as this
technology develops.

RECOMMENDATION

In light of these considerations, your Board of Trustees recommends that the following be adopted
and the remainder of this report be filed:

As a leader in American medicine, our American Medical Association (AMA) has a unique
opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits
patients, physicians, and the health care community. To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving
   patient outcomes and physicians’ professional satisfaction to help set priorities for health
care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the
development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
   a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
   b. is transparent;
   c. conforms to leading standards for reproducibility;
   d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
   e. safeguards individuals’ privacy interests and preserves the security and integrity of personal information.

4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.

5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. (New HOD Policy)

Fiscal Note: $5000.
REFERENCES


Whereas, Obesity has been recognized by our AMA as a disease (AMA Policy H-440.842); and

Whereas, There are many evidence-based, effective and safe treatment options for obesity including intensive lifestyle intervention\(^1\),\(^2\), pharmacotherapy\(^4\), and surgery\(^5\); and

Whereas, Our AMA "will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions) (D-440.954);"\(^6\) and

Whereas, Weight-bias is a significant problem in our society, at the state and federal level, and even in our health-care system with most patients affected by obesity often being victims of weight-bias including from their health care provider (H-440.821); and

Whereas, Our AMA has recognized that medical education regarding evidence-based treatment is inconsistent and inadequate\(^6\); and

Whereas, Pharmacotherapy for obesity has been proven to safely and effectively double to triple the odds of losing 5-10% body weight, an amount that has been proven to prevent diabetes, improve blood pressure and decrease health care costs\(^7\); and

Whereas, Current state and federal regulations make it even more difficult for healthcare providers to provide treatment:

- Medicare does not allow payment for any anti-obesity medication (AOM) due to an out-of-date policy, which prohibits Medicare from covering any “drugs for weight loss or weight gain.”

- Medicare further restricts payment for intensive lifestyle intervention to primary care providers in the primary care setting. For this reason, this benefit is scarcely being used.

- Our AMA has already supported the Treat and Reduce Obesity Act (TROA)\(^8\) in the 114th Congress, and will continue to support the bill in the 115th congress, H.R. 1953/S. 830 – legislation that would eliminate the Medicare Part D prohibition on weight loss medications and allow other qualified health care providers such as registered dietitians and social workers to provide behavioral treatment.

- Most states allow physicians to utilize FDA medications for off-label uses to treat chronic conditions should these practices be viewed as within the standard of care for that

---


\(^2\) Centers for Medicare and Medicaid Services (CMS), November 29\(^1\), 2011


\(^4\) https://doi.org/10.1210/jc.2015-1782, accessed 1/15/2018

\(^5\) http://www.nejm.org/doi/full/10.1056/NEJMoa062544#t=article, accessed 1/15/2018

\(^6\) Council on Medical Education Report CME-3, Obesity Education at a17


condition. However, this is not the case in some areas of the country regarding off-label prescribing for AOMs\(^9,10\). For example, some older drug labels state that the medications are for “short-term” use only, which is now inconsistent with what we know about the chronic nature of obesity. It has been proven that treatment is only effective so long as it is continued as is the case with all chronic disease such as diabetes and heart disease. Current publications including one from our Endocrine colleagues\(^11\) call for chronic prescribing of all AOMs, and include guidelines to be used for safe prescribing of these older medications; and

Whereas, The use of AOMs long-term for obesity has been approved by the FDA for our 4 newest drugs, and recent studies of our older drugs shows that “abuse or psychological dependence (addiction) does not occur…”\(^12\), and

Whereas, Due to these issues and many others, patients affected by obesity are unlikely to receive proper evidence-based treatments including behavioral intervention and medication. Current research shows that only 2\% of patients affected by obesity with an on-label indication for pharmacotherapy are receiving medication. In contrast, 86\% of patients affected by type 2 diabetes receive pharmacotherapy\(^13\); therefore be it

RESOLVED, That our American Medical Association work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment (Directive to Take Action); and be it further

RESOLVED, That our AMA actively lobby with state medical societies and other interested stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

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

Received: 03/21/18

RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842 - Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. Res. 420, A-13

Addressing Obesity D-440.954 - 1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. 2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). BOT Rep. 11, I-06 Reaffirmation A-13 Appendixed: Sub. Res. 111, A-14 Modified: Sub. Res. 811, I-14

Person-First Language for Obesity H-440.821 - Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully. Res. 402, A-17 Modified: Speakers Rep., I-17

\(^9\) http://www.med.ohio.gov/Portals/0/DNN/PDF-FOLDERS/PRESCRIBER-RESOURCES-PAGE/Weight-Loss-Drugs/PrescribingQsymiaBelviqforChronicWeightManagement.pdf


\(^11\) https://doi.org/10.1210/jc.2015-1782, accessed 1/15/2018

\(^12\) https://www.ncbi.nlm.nih.gov/pubmed/23736363/, accessed 1/24/2018

Whereas, There are numerous electronic health record (EHR) vendors in the medical marketplace for physicians and health systems to use; and

Whereas, Physicians and health care systems may determine that a new EHR vendor is more cost effective, provides enhanced functionality to clinical workflows and patient data management, and offers superior service and support; and

Whereas, The high cost and extensive time required to transition health IT data to a new EHR system is often a barrier preventing such a change; and

Whereas, Patient data is often lost during EHR transition due to a lack of standardized data and transition protocols among EHR vendors; and

Whereas, These barriers that physicians and health systems face when considering EHR vendor transition often have the practical effect of locking physicians and health systems into continuing to use the same EHR, despite of known EHR deficiencies; and

Whereas, These barriers enable EHR vendors to benefit from lack of open competition in the marketplace; therefore be it

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

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

Received: 04/03/18
RELEVANT AMA POLICY

National Health Information Technology D-478.995 - 1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery. 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology’s (ONC) certification process. 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability. 8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records. Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Appended: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17

Principles for Hospital Sponsored Electronic Health Records D-478.973 - 1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC). 2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production. 3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs. 4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship. Citation: (BOT Rep. 1, I-15)

Information Technology Standards and Costs D-478.996 - 1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. 2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards. Citation: Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17

See also: EHR Interoperability D-478.972
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-18)

Introduced by: District of Columbia

Subject: Updating Federal Food Policy to Improve Nutrition and Health

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, Prior to the mid-1960s, lactose intolerance was believed to be a rare, abnormal condition causing abdominal pain and diarrhea after milk consumption; and

Whereas, Research since the 1960s has shown that lactose intolerance (lactase non-persistence) is normal and is present in the majority of African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often beginning in childhood; and

Whereas, Children with lactose intolerance may not request an alternative to cow’s milk unless they provide documentation from a medical authority, parent, or guardian of a medical or special dietary need, and even with such documentation, schools may refuse such requests; and

Whereas, Requiring children to obtain documentation of a “medical or special dietary need” when they have a normal condition may stigmatize children and discourage them from requesting foods they can safely digest and unnecessarily consumes physicians’ time and families’ time and resources; and

Whereas, African Americans are at particularly high risk for prostate cancer, colorectal cancer, and cardiovascular mortality; and

Whereas, Prostate and colorectal cancer are strongly linked to dairy consumption and processed and red meat consumption, respectively, which are promoted in federal nutrition policies, and these same products contribute to cardiovascular risk; and

Whereas, Dairy and meat products are not nutritionally required; therefore be it

RESOLVED, That our American Medical Association amend existing AMA Policy D-440.978, “Culturally Responsive Dietary and Nutritional Guidelines,” by addition to read as as follows:

D-440.978 Culturally Responsive Dietary and Nutritional Guidelines. Our AMA and its Minority Affairs Section will: (1) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (2) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; (3) recognize that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often manifesting in childhood; and (34) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care. (Modify Current HOD Policy); and be it further
RESOLVED, That our AMA propose legislation that modifies the National School Lunch Act, 42 U.S.C. § 1758, so as to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cow’s milk (Directive to Take Action); and be it further

RESOLVED, That our AMA recommend that the U.S. Department of Agriculture and U.S. Department of Health and Human Services clearly indicate in the Dietary Guidelines for Americans and other federal nutrition guidelines that meat and dairy products are optional, rather than recommended or required. (New HOD Policy)

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

Received: 04/13/18

RELEVANT CITATIONS


RELEVANT AMA POLICY

Racial and Ethnic Disparities in Health Care H-350.974 - 1. 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 is an issue of highest priority for the American Medical Association. 2. The AMA emphasizes three approaches that it believes should be given high priority: A. 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. B. 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. C. 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 3. 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. 4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. CLRPD Rep. 3, I-98 Appended and Reaffirmed: CSA Rep. 1, I-02 Reaffirmed: BOT Rep. 4, A-03 Reaffirmed in lieu of Res. 106, A-12 Appendeed: Res. 952, I-17

Combating Obesity and Health Disparities H-150.944 - Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol. Res. 413, A-07 Reaffirmation A-12 Reaffirmation A-13 Modified: CSAPH Rep. 03, A-17

Culturally Responsive Dietary and Nutritional Guidelines D-440.978 - Our AMA and its Minority Affairs Section will: (1) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (2) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; and (3) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care. BOT Rep. 6, A-04 Modified: CSAPH Rep. 1, A-14

See also: Obesity as a Major Health Concern H-440.902
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-18)

Introduced by: Louisiana
Subject: Opposition to Mandated Proficiency in EHR for Licensure
Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, The State of Massachusetts requires that on or after January 1, 2015, a renewing full
licensee must demonstrate proficiency in the use of electronic health records, as required by
M.G.L. c. 112, § 2 and 243 CMR 2.06(2)(d); and

Whereas, The Louisiana State Medical Society has policy supporting an exception for the
requirements that physicians use secure electronic communication with patients; and

Whereas, The Louisiana State Medical Society has policy stating that no physician should be
denied a medical license solely on the grounds of failure to use an electronic health record, or
failure to demonstrate proficiency in use of an electronic health record; therefore be it

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

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

Received: 04/11/18

RELEVANT AMA POLICY

Licensure for Physicians Not Engaged in Direct Patient Care H-275.921 - Our AMA: (1) opposes laws,
regulations, and policies that would limit the ability of a physician to obtain or renew an unrestricted state or territorial
medical license based solely on the fact that the physician is engaged exclusively in medical practice which does not
include direct patient care; (2) advocates that the Federation of State Medical Boards support provision of
unrestricted state or territorial medical licenses to physicians engaged in medical practice that does not include direct
patient care; (3) urges constituent state and territorial medical societies to advocate with their respective medical
boards to establish policy that will facilitate provision of unrestricted state or territorial medical licenses to physicians
in medical practice that does not include direct patient care; and (4) opposes activities by medical licensure boards to
create separate categories of medical licensure solely on the basis of the predominant professional activity of the
practicing physician. Citation: Res. 923, I-10

Discrimination Against Physicians Under Supervision of Their Medical Examining Board H-275.949 - 1. Our
AMA opposes the exclusion of otherwise capable physicians from employment, business opportunity, insurance
coverage, specialty board certification or recertification, and other benefits, solely because the physician is either
presently, or has been in the past, under the supervision of a medical licensing board in a program of rehabilitation or
enrolled in a state-wide physician health program. 2. Our AMA will communicate Policy H-275.949 to all specialty
boards and request that they reconsider their policy of exclusion where such a policy exists. Citation: Sub. Res. 3, A-
412, A-12 Reaffirmed: BOT action in response to referred for decision Res. 403, A-12

Physician Licensure Legislation H-275.955 - Our AMA reaffirms earlier policy urging licensing jurisdictions to adopt
laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for

Medical Licensure H-275.978 - The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. Citation: CME Rep. A, A-87Modified: Sunset Report, I-97Reaffirmation A-04Reaffirmed: CME Rep. 3, A-10Reaffirmation I-10Reaffirmed: CME Rep. 6, A-12Appended: Res. 305, A-13Reaffirmed: BOT Rep. 3, I-14

Implementing Electronic Medical Records H-478.993 - It is the policy of our AMA that public and private insurers should not require the use of electronic medical records. Citation: Sub. Res. 707, A-06Reaffirmation A-07Reaffirmed in lieu of Res. 237, A-12Reaffirmation A-14

Allocation of Privileges to Use Health Care Technologies H-480.988 - The AMA (1) affirms the need for the Association and specialty societies to enhance their leadership role in providing guidance on the training, experience and knowledge necessary for the application of specific health care technologies; (2) urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and (3) asserts that licensure of physicians by states must be based on scientific and clinical criteria. Citation: BOT Rep. F, I-88Reaffirmed: CME Rep. 8, I-93Reaffirmed: CME Rep. 2, A-05Reaffirmed: CME Rep.1, A-15
Whereas, Our AMA has recently become involved in efforts to figure out how to incorporate Augmented Intelligence (AI) into the health care system; and

Whereas, There are advantages to the utilization of AI in the day-to-day care of patients; and

Whereas, It will be very expensive to incorporate AI into the day-to-day care of patients; and

Whereas, Physicians can take care of most patients without the assistance of AI; and

Whereas, The cost of implementing AI may take money away from the financing of essential health services; and

Whereas, At this time, many patients do not have 24-7 access to a primary care physician who can see the medical records of the patients; and

Whereas, The American Academy of Pediatrics believes that it is very important for all people to be enrolled in a medical home so that all patients can have 24-7 access to a primary care physician who can see their medical records; therefore be it

RESOLVED, That our American Medical Association develop Augmented Intelligence (AI) policy that reflects the principle that all patients should have 24-7 access to primary care physicians who can see the medical records of the patients (New HOD Policy); and be it further

RESOLVED, That AI should be funded as an enhancement of the primary care medical home so that patients who really need AI can benefit from the technology and such that AI does not become a requirement that must be incorporated into the care of every patient. (New HOD Policy)

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

Received: 04/19/18
Whereas, The patient centered medical home is considered the optimal way to provide high quality, cost-effective, comprehensive, and continuous primary care to patients; and

Whereas, The use of telehealth services, providing healthcare remotely to patients via computer and video links, has been proposed as an extension of physician healthcare services with the potential to supplement the medical home and provide care where health care services are not easily accessible; and

Whereas, The use of telehealth services has seen rapid growth in the past few years, supported and promoted by insurance companies, for-profit health care businesses, and hospital systems primarily as cheaper, easier, and faster than an in-person physician visit; and

Whereas, Some telehealth systems lure patients to telehealth care by providing patients with financial incentives (lower fees and co-pays); and

Whereas, The use of telehealth services outside the medical home of the patient, as currently promoted by for-profit health care entities, undermines the medical home as the optimal source for provision and coordination of patient care; and

Whereas, It is understood that there are emergency medicine and critical care telehealth modalities, and other applications of telehealth (save and forward radiology, pathology, and dermatology) that occur outside the realm of the primary care medical home; and

Whereas, Telehealth care cannot involve a personal, face-to-face interview and physical examination (even in those systems which use instruments at the patient’s site manipulated by the patient or another person) and laboratory testing, which may be crucial to making an accurate diagnosis; and

Whereas, Telehealth systems are providing diagnoses for patients with sore throat, dysuria, congestion/cough and other symptoms without performing adequate physical and laboratory assessments, resulting in inappropriate antibiotic prescribing; and

Whereas, Certain patient populations (including infants and children, developmentally disabled individuals, and patients with complicated medical histories) may not be able to adequately provide accurate history or participate in any limited telehealth physical examination or decision making, leading to inaccurate, and potentially harmful, prescribing and treatment practices by telehealth providers; therefore be it
RESOLVED, That our American Medical Association work with relevant stakeholders to ensure
that all telehealth services are provided by and organized within the confines of the medical
home, including financial incentives to utilize the telehealth modality outside the medical home
(Directive to Take Action); and be it further

RESOLVED, That our AMA advocate at both the state and national level that all telehealth
vendors be required to collect and report quality measures in the context of clinical guidelines
developed by reputable national specialty organizations (Directive to Take Action); and be it
further

RESOLVED, That our AMA work with relevant stakeholders to accumulate quality of care,
patient satisfaction, and outcome data to compare telehealth with face-to-face care. (Directive to
Take Action)

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

Received: 04/19/18
Whereas, One of the major causes of physician burn-out is the redundancy and time involved in meeting quality improvement requirements to prove to hospitals, payers, licensing agencies, and specialty boards that physicians are practicing good medicine; and

Whereas, It is very expensive for physicians to meet the quality improvement requirements of payers, hospitals, licensing agencies, and specialty boards; and

Whereas, Our AMA could do more to help physicians convince payers, hospitals, licensing agencies, and specialty boards that physicians should be able to utilize one menu of quality improvement activities in order to meet the quality improvement requirements of the multiple entities that need proof that physicians are practicing good medicine; therefore be it

RESOLVED, That our American Medical Association develop a quality improvement initiative so that if physicians complete quality improvement requirements of their specialty boards, that payers, hospitals, and licensing agencies will accept the specialty board certification evidence that physicians are practicing good medicine and will not require physicians to meet separate quality improvement requirements of payers, hospitals, and licensing agencies. (Directive to Take Action)

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

Received: 04/19/18
Introduced by: Pennsylvania

Subject: Prior Authorization Requirements for Post-Operative Opioids

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, Physicians and practitioners who care for patients strive to give timely, compassionate and evidence based medical care that may involve narcotic prescriptions; and

Whereas, Insurers do not know the circumstances prompting the narcotic prescription; and

Whereas, Postoperative patients often require brief opioid prescriptions for pain management; and

Whereas, Some patients have been denied postoperative pain relief due to time consuming and inappropriate prior authorization; therefore be it

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

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

Received: 04/24/18
Whereas, Three states consider substance use in pregnancy a crime and another three states consider substance abuse grounds for civil commitment\(^1\); and

Whereas, Twenty-four states and DC consider drug use in pregnancy child abuse\(^1\); and

Whereas, Women have been prosecuted for drug use in pregnancy in 43 states\(^1\); and

Whereas, The mandatory reporting or toxicology testing requirements for suspected substance use in certain states may result in women concealing their use or foregoing prenatal care\(^2\); and

Whereas, Incarceration of pregnant women is not associated with improved pregnancy outcomes. Rather, opioid agonist therapy in conjunction with prenatal care decreases the risk of obstetric complications\(^3\); therefore be it

RESOLVED, That our American Medical Association reaffirm Policy H-420.969 (#4) so as to oppose any legislation that seeks to specifically penalize women who are diagnosed with a substance abuse disorder during pregnancy (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation for the expansion and improved access to evidence-based treatment for substance abuse disorders during pregnancy without mandating any specific form of therapy. (Directive to Take Action)

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

Received: 04/24/18

\(^1\) https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy
RELEVANT AMA POLICY

Perinatal Addiction - Issues in Care and Prevention H-420.962
Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

Legal Interventions During Pregnancy H-420.969
Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women: (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.
(2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
(3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
(4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
(5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
(6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation.

Opiate Replacement Therapy Programs in Correctional Facilities H-430.987
1. Our AMA endorses: (a) the medical treatment model of employing opiate replacement therapy (ORT) as an effective therapy in treating opiate-addicted persons who are incarcerated; and (b) ORT for opiate-addicted persons who are incarcerated, in collaboration with the National Commission on Correctional Health Care and the American Society of Addiction Medicine.
2. Our AMA advocates for legislation, standards, policies and funding that encourage correctional facilities to increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of opioid replacement therapy in conjunction with counseling, in correctional facilities within the United States and that this apply to all incarcerated individuals including pregnant women.
3. Our AMA supports legislation, standards, policies, and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including pregnant women, are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths and help ensure post-incarceration medical coverage and accessibility to medication assisted therapy.
Whereas, Mass Shootings of innocent victims have become more prevalent in America; and

Whereas, Shooters in such episodes are increasingly using semi-automatic weapons (1 pull of trigger produces one bullet and reloads the chamber, but the next shot requires a 2nd pull of the trigger) and/or weapons altered to make them function in an automatic manner (1 pull of the trigger continuously fires bullets until the trigger is released); and

Whereas, Ownership of fully-automatic weapons (aka “machine guns”), noise suppressors, short barreled rifles, short barreled shotguns as well as explosive devices such as bombs and grenades have been highly restricted in the United States of America since passage of the 1934 National Firearms Act (revised in 1968 and 1986); and

Whereas, A bump stock is a device, available for under $200, that converts a semi-automatic rifle to function like a fully-automatic weapon; and

Whereas, Examples of recent mass shootings that involved either a semi-automatic weapon or a semi-automatic weapon modified to function in an automatic mode include:

- At an elementary school in Newtown, CT, a man armed with a semi-automatic rifle killed 28 people and wounded two others;
- In a movie theater in Aurora, CO, a man armed with a semi-automatic rifle killed 12 people and wounded 58 others;
- At a holiday party in San Bernadino, CA, a man and woman armed with semi-automatic rifles killed 14 people and wounded 20 others;
- At a nightclub in Orlando, FL, a man armed with a semi-automatic rifle killed at least 50 people and wounded 53 others;
- At an outdoor country music festival in Las Vegas, NV, a man armed with a rifle modified with a bump stock killed 59 people and wounded 545 others; and

Whereas, Physicians pledge their careers to saving lives, promoting health, and preventing injury or premature death; therefore be it

RESOLVED, That our American Medical Association support legislation that blocks the sale of any device or modification, including but not limited to bump stocks, that functionally converts a firearm into a weapon that mimics fully-automatic operation (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that would ban the sale and/or ownership of high capacity magazines or clips and high-speed-high-destruction rounds. (New HOD Policy)
RELEVANT AMA POLICY

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18;
(c) the imposition of significant licensing fees for firearms dealers;
(d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(e) mandatory destruction of any weapons obtained in local buy-back programs.
(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
Resolved, that our American Medical Association seek clarification from the United States Justice Department about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, provide guidance to physicians. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Whereas, The Merit-based Incentive Payment System (MIPS) was created as part of the Quality Payment Program (QPP) under the Medicare Access CHIP Reauthorization Act of 2015 (MACRA) to institute a new “value-based” payment system for physicians; and

Whereas, MIPS adjusts payments based on performance in the categories of: Quality; Cost; Meaningful Use; and Improvement activities; and

Whereas, Compliance with this program involves the navigation of a labyrinth of rules and regulations; and an alphabet soup of acronyms that constitutes an unreasonable burden on physicians; taking time and energy away from the care of patients; and

Whereas, The “value-based” payment system involves a huge bureaucracy which results in the waste of health care dollars; and

Whereas, There is no evidence that this system of payment helps physicians to care for patients or improves the health of patients, which is the true mission of our profession; therefore be it

RESOLVED, That our American Medical Association work to repeal the law that conditions a portion of a physician’s Medicare payment on compliance with the Medicare Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM) programs (Directive to Take Action); and be it further

RESOLVED, That our AMA continue advocating for a reduction in the administrative burdens of compliance with value-based programs and that these programs comply with evidence-based standards. (Directive to Take Action)

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

Received: 04/25/18
RELEVANT AMA POLICY

MACRA and the Independent Practice of Medicine H-390.837
1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.
3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.
Alt. Res. 206, A-17

MIPS and MACRA Exemption H-390.838
Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.
Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17
WHEREAS, Retrospective chart review is commonly used by insurers and others to determine their perspective on appropriateness of hospital admission, length of stay in other payment parameters; and

WHEREAS, Guidelines for hospital admission and length of stay in other clinical parameters are set by the Centers for Medicare and Medicaid Services (core measures, quality metrics, etc.); and

WHEREAS, These guidelines are constantly changing and being updated by CMS; and

WHEREAS, Retrospective chart review may occur two years or more after the service has been rendered and paid for; and

WHEREAS, Insurance companies, peer review organizations and others retrospectively review two-year-old charts using current guidelines, resulting in adverse determinations based on these new guidelines that were not in place at the time that the care was provided; and

WHEREAS, Unfair judgments are being rendered on payment for services provided in a different regulatory environment than when the service was provided; therefore be it

RESOLVED, That our American Medical Association seek legislation/regulation that requires insurance companies, peer review organizations and the Centers for Medicare and Medicaid Services to use the review criteria that existed at the time that services were provided when making their determinations. (Directive to Take Action)

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

Received: 04/25/18
RELEVANT AMA POLICY

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
It is the policy of our AMA, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal.

Physicians’ Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995
(1) Our AMA will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization.
(2) Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review. (3) AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to (a) develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims, (b) seek information on a regular basis from those associations that collect such information, and (c) respond with appropriate legislation, advocacy, and communication initiatives.

See also: Managed Care H-285.998
WHEREAS, Mass shootings of innocent victims have become more prevalent in America; and

WHEREAS, Most mass shooters have obtained pistols, long guns and explosives legally, though some shooters might have been prevented from obtaining weapons had background checks been properly performed; and

WHEREAS, Many states have a background check system to block criminals and persons with severe mental health problems from being able to purchase pistols, long guns and explosives (such as grenades, rocket propelled grenades, dynamite, C4, etc.); and

WHEREAS, Incomplete use of the background check system in private sales, gun show and online sales makes it much easier for individuals to obtain guns without undergoing a background check; therefore be it

RESOLVED, That our American Medical Association support legislation that requires a waiting period and background checks prior to the purchase of all firearms, including the person-to-person transfer, internet sales, and interstate transactions of all firearms. (New HOD Policy)

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

Received: 04/25/18

REFERENCES:
Sources of weapons used in mass shootings https://www.nytimes.com/interactive/2015/10/03/us/how-mass-shooters-got-their-guns.html
OMH Automated Background Check System https://www.omh.ny.gov/omhweb/mhbc/
National Instant Background Check System https://www.fbi.gov/services/cjis/nics
RELEVANT AMA POLICY

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Firearm Availability H-145.996
Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers; (2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
Whereas, Hospitals in the United States spend an estimated 1.5 billion dollars per year in advertising; and furthermore, it is likely that hospital advertising drives up healthcare costs even more by promoting inefficient, inappropriate and/or unnecessary healthcare utilization; and

Whereas, The content of hospital advertising is generally devoid of information that helps consumers make meaningful choices about their health care, is often misleading and does not lead to improved health outcomes; and

Whereas, Well over 50% of hospital revenue is received from Medicare and Medicaid which ought to make hospital advertising an obligatory subject of public scrutiny and government oversight; and

Whereas, The Supreme Court has upheld an FTC ruling which invalidated the long-standing AMA ban on physician and hospital advertising, making an immediate outright prohibition of hospital advertising unlikely; therefore be it

RESOLVED, That our American Medical Association advocate for regulations which promote responsible hospital and medical advertising. (New HOD Policy)

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

Received: 04/25/18
Whereas, The Food and Drug Administration (FDA) relies on Advisory Committees, composed of pharmacology and other healthcare experts, to review scientific studies of a proposed new drugs or medical devices;\textsuperscript{1,2,3} and

Whereas, The FDA formally prohibits the hiring of Advisory Committee members with conflicts of interest including employment by the sponsor of the drug under review and stock in the sponsoring company but routinely grants waivers instead of disqualifying such individuals;\textsuperscript{1-3} and

Whereas, The FDA only considers individuals to be conflicted if they have conflicts of interest that occurred in the past 12 months, which is shorter than the standard 36 month period that is customary in the scientific community;\textsuperscript{3,4,5,6} and

Whereas, The FDA in 2007 imposed a cap on the number of conflict of interest waivers that may be granted to Advisory Committee members through the FDA Amendments Act (FDAAA);\textsuperscript{3,4} and

Whereas, The FDA loosened conflict of interest restrictions with the passage of the Food and Drug Safety and Innovation Act (FDASIA) in 2012 by lifting the 2007 cap imposed by the FDAAA on the number of available conflict of interest waivers;\textsuperscript{3,4} and

Whereas, The FDASIA deprioritized conflicts of interest by eliminating the weight a financial disclosure had on a candidate’s selection;\textsuperscript{3,4,7,8,9,10,11} and

Whereas, The impact of Advisory Committee conflicts of interest on voting tendencies introduces bias to the review process and has led to the passage of drugs that were later\textsuperscript{1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25}

\begin{thebibliography}{99}
\bibitem{Conflicts2005} Conflicts of Interest on COX-2 Panel. \textit{Center for Science in the Public Interest.} February 5, 2005.
\bibitem{Pham-Kanter2014} Pham-Kanter G. Revisiting financial conflicts of interest in FDA advisory committees. \textit{Milbank Q.} 2014;92(3):446-470.
\end{thebibliography}
recalled due to safety concerns or linked to significant adverse effects such as with the Vioxx and Yaz/Yasmin scandals, respectively;\textsuperscript{3,4,7-12} and

Whereas, The use of Advisory Committee Members with direct conflicts of interest undermines public trust in drug safety and presents a possible danger to the public health and safety;\textsuperscript{13,14} and

Whereas, Research suggests there are a sufficient number of non-conflicted medical experts to fill Advisory Committee vacancies;\textsuperscript{3,15} and

Whereas, Our AMA has policy advocating for the use of sound scientific evidence as the basis of drug evaluations (AMA Policy H-100.992) and policy stating that it will monitor and respond to drug safety practices at the FDA (D-100.978); therefore be it

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

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

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

Date Received: 04/26/18

RELEVANT AMA POLICY

H-100.992 FDA

(1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug’s approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.

(2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.

(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

Citation: (Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appendix: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10)

See also: FDA Drug Safety Policies D-100.978


\textsuperscript{14}Kowitt SD, Schmidt AM, Hannan A, Goldstein AO. Awareness and trust of the FDA and CDC: Results from a national sample of US adults and adolescents. PloS one. 2017;12(5):e0177546.


AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-18)

Introduced by: Medical Student Section

Subject: Reforming the Orphan Drug Act

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, Congress passed the Orphan Drug Act (ODA) of 1983 in response to declining pharmaceutical investment of “orphaned” drugs through clinical trials following the Kefauver-Harris amendments of 1962 because of increased development costs;\(^1\)\(^2\)\(^3\) and

Whereas, The “orphan” designation is intended to incentivize the creation of drugs that target rare conditions affecting fewer than 200,000 Americans which are often deemed “unprofitable” due to the difficulty of recuperating development and marketing costs;\(^4\)\(^5\)\(^6\)\(^7\) and

Whereas, Although the ODA has been credited for introducing over 400 orphan drugs since becoming law, physicians, researchers, and policymakers have raised concerns about potential abuses of the Act;\(^1\)\(^3\)\(^8\)\(^9\)\(^10\) and

Whereas, Though the Act’s original intent was to incentivize the development of “non-profitable” therapies treating fewer than 200,000 Americans, several drugs have obtained “blockbuster” status indicating >$1 billion in sales annually, sometimes through a multitude of loopholes;\(^1\)\(^4\)\(^9\) and

Whereas, One such loophole is the approval for “orphan designation” - and therefore, ODA benefits - of existing compounds and mass-market drugs, as is the case for 3,4-DAP, ascorbic acid, calcium carbonate, Humira, and Crestor;\(^8\)\(^11\)\(^12\)\(^13\) and

Whereas, A pharmaceutical company may strategically submit a drug for approval of a single indication - “one that is narrow enough to qualify for orphan drug benefits” - and once approved, the drug is utilized for a variety of off-label uses, as demonstrated by the drugs rituximab, modafinil, and a variety of oncology drugs;9,14,15 and

Whereas, The exploitation of loopholes within the Act have resulted in both exorbitant price hikes and increasing sales, contributing up to one-fifth of global prescription sales by 2020 despite the original purpose of treating small populations;9,16,17 and

Whereas, Multiple pieces of legislation pertaining to the Orphan Drug Act have been submitted by both parties in the 115th Congress, which along with recent action by the FDA, indicates legislative and regulatory awareness of improvements that can be made and a will to do so;16,17 therefore be it

RESOLVED, That our American Medical Association support efforts to reform the Orphan Drug Act by closing loopholes identified by the Food and Drug Administration in order to protect the Act’s original intent of promoting therapies targeting rare diseases (New HOD Policy); and be it further

RESOLVED, That our AMA support increased transparency in development costs, post-approval regulation and overall earnings for pharmaceuticals designated as “Orphan Drugs” (New HOD Policy); and be it further

RESOLVED, That our AMA support modifications to the exclusivity period of “Orphan Drugs” to increase access to these pharmaceutical drugs for patients with rare diseases. (New HOD Policy)

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

Received: 04/26/18

RELEVANT POLICY:
Pharmaceutical Cost H-110.987
Cost of Prescription Drugs H-110.997
Cost of New Prescription Drugs H-110.998
Viability of Clinical Research Coverages and Reimbursement H-460.965

Whereas, Feminine hygiene products are defined as “tampons, pads, liners, cups, sponges, douches, wipes, sprays, and similar products used by women with respect to menstruation or other genital-tract secretions”;¹ and

Whereas, Our AMA defines medical necessity as a product a physician “would provide for the purpose of preventing” an illness, disease, or its symptoms (AMA Policy H-320.953) and supports the evaluation of medical necessity “based on established and evidence-based clinical criteria” (H-320.942); and

Whereas, Poor menstrual hygiene is correlated with significant adverse health effects, including increased urogenital infections and cervical cancer;²,³,⁴,⁵,⁶,⁷ and

Whereas, Poor menstrual health is associated with significant healthcare costs and a reduced quality of life, especially in women with heavy menses;⁸ and

Whereas, The biggest barriers to adequate feminine hygiene are affordability and accessibility;⁴,⁶,⁹,¹⁰ and

Whereas, Women who are incarcerated, homeless, or of low socioeconomic status often resort to cheaper and less sanitary alternatives such as newspapers and used rags, and are therefore particularly vulnerable to health complications caused by poor menstrual hygiene;⁶,⁷,¹¹,¹²,¹³ and

¹ H.R. 1708 to amend the Public Health Service Act to establish a program of research regarding the risks posed by the presence of dioxin, synthetic fibers, chemical fragrances, and other components of feminine hygiene products, H.R. 2015. HR 1708, 114th Cong.
Whereas, Women who qualify for the Supplemental Nutrition Assistance Program (SNAP) do not receive financial assistance for feminine hygiene products and women often resort to trading food stamps in order to buy menstrual products;⁵,¹⁴ and

Whereas, The Internal Revenue Service (IRS) does not classify feminine hygiene products, such as pads and tampons, as medical necessities, wrongfully implying that menstrual products are not required for prevention, treatment, or diagnosis of a medical condition;¹⁵ and

Whereas, The Food and Drug Administration (FDA) classifies menstrual products as medical devices, and they are regulated as such;¹⁵ and

Whereas, AMA policy recognizes access to feminine hygiene products as a public health issue and supports the removal of sales tax on all feminine hygiene products (H-270.953); therefore be it

RESOLVED, That our American Medical Association encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Tax Exemptions for Feminine Hygiene Products H-270.953
Our AMA supports legislation to remove all sales tax on feminine hygiene products.
Citation: Res. 215, A-16;

Medical Necessity and Utilization Review H-320.942
Our AMA supports efforts to: (1) ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care; and (2) ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery.
Citation: Res. 810, I-16;

See also:
Health Care While Incarcerated H-430.986
Definitions of “Screening” and “Medical Necessity” H-320.953


Whereas, Kidney transplantation is often the best and most cost-effective treatment for Medicare patients with End Stage Renal Disease (ESRD); and

Whereas, The Dialysis PATIENTS Demonstration Act of 20171 (S. 2065) (HR 4143)--PATIENTS Act--appears to remove control of kidney transplantation decision-making from many physicians and their Medicare patients; and

Whereas, The PATIENTS Act is duplicative of the more comprehensive and patient-oriented Center for Medicare and Medicaid Innovation Comprehensive ESRD Care Model2; and

Whereas, Dialysis and transplant professional3,4,5 as well as patient-centered groups5,6 oppose the PATIENTS Act because it limits physician and patient choice in ESRD treatment options; therefore be it

RESOLVED, That our American Medical Association work with professional and patient-centered organizations to advance patient and physician-directed coordinated care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further

RESOLVED, That our AMA actively oppose the “Dialysis PATIENTS Demonstration Act of 2017” (S. 2065) (HR 4143) (Directive to Take Action); and be it further

RESOLVED, That the House of Delegates receive a report back at the 2018 Interim Meeting regarding our AMA actions in opposing the PATIENTS Act (Directive to Take Action)

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

Received: 04/27/18

---

2 Center for Medicare and Medicaid Innovation Comprehensive ESRD Care Model: https://innovation.cms.gov/initiatives/comprehensive-esrd-care/
6 The FAIR Foundation: www.FAIRfoundation.org: Policy adopted 28 January, 2018
RELEVANT AMA POLICY

Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962
Our AMA supports federal funding of organ transplants for Medicaid patients.
Citation: (BOT Rep. 15, A-13)

Ethical Procurement of Organs for Transplantation H-370.967
Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary.
Citation: (BOT Rep. 13, A-08)

UNOS Kidney Paired Donation Program H-370.960
Our AMA: (1) encourages the continued expansion of the United Network for Organ Sharing’s (UNOS) Kidney Paired Donation program which provides a national registry of living donors, carries out ongoing data collection on key issues of concern in transplantation from living donors, and through its operational guidelines provides consistent, national standards for the transplant community; and (2) encourages voluntary coordination among private donor registries and UNOS to enhance the availability of organs for transplantation.
Citation: (BOT Action in response to referred for decision Res. 2, A-13)

Cost-Saving Public Coverage for Renal Transplant Patients H-370.963
1. Our AMA supports private and public mechanisms that would extend insurance coverage for evidence-based treatment of renal transplant care for the life of the transplanted organ.
2. Our AMA will continue to offer technical assistance to individual state and specialty societies when those societies lobby state or federal legislative or executive bodies to implement evidence-based cost-saving policies within public health insurance programs.
Citation: (Res. 104, A-13)
Whereas, The United States struggles with an epidemic of firearm violence; in 2015, there were 34,997 deaths in the U.S. that were caused by firearms. Mass shootings account for a small percentage of firearm violence deaths yet result in unnecessary morbidity and mortality; and

Whereas, Firearms employing “high velocity” firepower were designed for the military to provide massive tissue destruction and obliteration of the enemy. The classic military model is the M-16 and the common civilian counterpart is the AR-15; and

Whereas, Such weapons have no appreciable value to U.S. civilians for use to defend themselves and have been repudiated by law enforcement for such use; and

Whereas, Major sports and hunting organizations have not supported the use of assault weapons for their members’ goals; and

Whereas, In 1994, Congress passed a ban on assault weapons and high capacity ammunition magazines and it lasted 10 years until it expired in 2004 and was not renewed. Compared with the 10-year period before the ban, the number of firearm massacres during the ban period fell by 37 percent, and the number of people dying from firearm massacres fell by 43 percent; and

Whereas, Assault weapons have increasingly been used in mass killing episodes since the federal ban lapsed in 2004. The use of assault weapons and high capacity magazines have increased by 183 percent in massacres and 239 percent in massacre deaths. Another study shows that assault-style weapons are showing up more often not only in mass shootings, but in ordinary crimes of violence and attacks on police officers. (Klarevas, LM Ramage Nation: Securing American from Mass Shootings. Amherst, New York; Pomeetheus Books, 2016. Koper, C.S., Johnson, W.D., Nichols, J.L. et al. J. Urban Health (2017). https://doi.org/10.1007/s11524-017-0205-7.); and

Whereas, Major states, such as California, have shown a diminution of killing episodes since permanently banning semi-automatic assault weapons in 1989 and high-capacity ammunition magazines in 1999; and

Whereas, There is no intent to infringe on current ownership of legally purchased firearms of any kind in this resolution; therefore be it

RESOLVED, That our American Medical Association urge Congress to pass legislation to ban the sale, transfer, manufacture, and importation of assault weapons and high-capacity ammunition magazines to the American public. (New HOD Policy)
Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/30/18

**RELEVANT AMA POLICY**

**Ban on Handguns and Automatic Repeating Weapons H-145.985**

It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

- mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
- bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18;
- the imposition of significant licensing fees for firearms dealers;
- the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
- mandatory destruction of any weapons obtained in local buy-back programs.

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

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

**Gun Violence as a Public Health Crisis D-145.995**

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and

(2) will actively lobby Congress to lift the gun violence research ban.

**Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975**

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.

**Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997**

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, nonreadily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

**See also:** Physicians and the Public Health Issues of Gun Safety D-145.997; Prevention of Unintentional Shooting Deaths Among Children H-145.979
Whereas, The U.S. Census data determines the allocation of more than $675 billion in federal funding to states and communities annually; and

Whereas, These funds provide for community development, public health, education, transportation and other community resource investments that are vital to decreasing the health, social and economic disparities experienced by vulnerable populations; and

Whereas, The 2020 Census is facing unprecedented challenges, such as a leadership void in the absence of an acting director, as well as insufficient funding; and

Whereas, There are resulting concerns about introduction of an internet-based format, scaled-back preparations and cybersecurity threats; and

Whereas, An inaccurate count will have significant consequences as the demographic data from the count are the bases for surveys that are benchmarks for major businesses, governments and researchers; therefore be it

RESOLVED, That our American Medical Association support adequate funding for the U.S. Census to assure accurate and relevant data is collected and disseminated. (New HOD Policy)

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

Received: 05/01/18
Whereas, The opioid epidemic has become a critical threat to public health in the U.S.¹; and
Whereas, Only 10 percent of individuals in the U.S. with an opioid use disorder obtain treatment¹; and
Whereas, Facilities that provide inpatient treatment for opioid use disorder usually do not use an evidence-based approach²,³ in that less than half of these facilities offer an FDA-approved medication for opioid use disorder; and
Whereas, The risk of a fatal overdose increases 25-fold in the month immediately after inpatient treatment of opioid use disorder without medication⁴, in part due to loss of opioid tolerance⁵; and
Whereas, Opioid overdose death is reduced by 50 percent by treatment with opioid agonist or partial agonist therapy (methadone or buprenorphine)⁶, which prevent loss of opioid tolerance; and
Whereas, Clinical guidelines indicate that the choice of treatment options should be a shared decision between the clinician and the patient⁷; and
Whereas, Our AMA has many policies regarding treatment of opioid use disorder, yet no policy addresses the central role that chemical dependency treatment programs play in treating opioid use disorder; therefore be it

References
³ “Where multiple modes of medication-assisted treatment are available,” Health Affairs Blog, January 9, 2018. DOI: 10.1377/hblog20180104.835958.
RESOLVED, That our American Medical Association advocate for legislation that eliminates barriers to, increases funding for, and requires access to opioid agonist or partial agonist therapy at all certified drug treatment facilities (New HOD Policy); and be it further

RESOLVED, That our AMA develop a public awareness campaign that medical treatment of opioid use disorder with agonist or partial agonist therapy is first-line treatment for this chronic disease. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/02/18
Whereas, The opioid epidemic has become a critical threat to public health in the U.S.\(^1\); and

Whereas, Hospitalizations have been rapidly increasing for opioid overdose and for infectious complications of injection drug use such as hepatitis C, HIV and deep-tissue bacterial infections, reaching 1.27 million emergency room and inpatient stays in 2014\(^2\); and

Whereas, Inpatient costs among those with opioid use disorder almost quadrupled to $15 billion between 2002 and 2012\(^3\); and

Whereas, There is a high risk of repeated hospitalization\(^4\) and overdose death following hospitalization due to loss of opioid tolerance\(^5\), and hospitals rarely address the underlying chronic disease of opioid use disorder\(^6,7\); and

Whereas, Medications approved by the Food and Drug Administration for treating opioid use disorder (buprenorphine, methadone and naltrexone) reduce illicit opioid use\(^1\); opioid agonist therapy (buprenorphine or methadone) reduces opioid overdose death by 50 percent\(^6\) in part by preventing loss of opioid tolerance; and buprenorphine provides further protection because of its high receptor affinity and ceiling effect on respiratory depression\(^8\); and

References

Whereas, Initiation of buprenorphine in the emergency department and inpatient setting and linkage to ongoing comprehensive treatment as an outpatient is an effective means for engaging patients and reducing illicit opioid use; and

Whereas, Our AMA has many policies regarding treatment of opioid use disorder, yet no policy addresses the central role that hospitals should play in treating opioid use disorder as a chronic disease; therefore be it

RESOLVED, That our American Medical Association’s Opioid Task Force work together with the American Hospital Association and other relevant organizations to develop recommendations and an implementation plan to encourage hospitals to treat opioid use disorder as a chronic disease, including identifying patients with this condition; providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; establishing appropriate discharge plans; and participating in community-wide systems of care for patients affected by this chronic disease (Directive to Take Action); and be it further

RESOLVED, That our AMA’s Opioid Task Force collaborate with relevant organizations to seek federal funding to assist hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder. (Directive to Take Action)

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

Received: 05/0218

Whereas, Opioid supply quotas and slow action from the Drug Enforcement Agency (DEA) have contributed to hospital shortages of injectable medications\(^1\); and

Whereas, Supply reductions may cause temporary shortages of oral opioid medications at specific community pharmacies; and

Whereas, Certain states mandate electronic prescribing of all controlled substances \(^2\)\(^3\); and

Whereas, Ongoing federal legislation may mandate electronic prescribing of all controlled substances nationwide \(^4\); and

Whereas, Unlike traditional paper prescriptions, unsuccessful electronic prescriptions are not physically portable; and

Whereas, Increased use of Prescription Drug Monitoring Programs (PDMPs) and electronic prescribing will better allow physicians and pharmacies to prevent pharmacy shopping by patients for whom the intent is prescription opioid diversion; and

Whereas, U.S. Drug Enforcement Administration regulations do not allow transfer of original electronic opioid prescriptions for Schedule II-V medications between pharmacies, allowing only one-time transfers of Schedule III-V medication refills \(^5\); and

Whereas, An unanticipated inability of a patient with bona fide pain to fill an opioid medication at a particular pharmacy after hours or on weekends constitutes a serious barrier to needed care, and may increase unnecessary emergency department utilization; therefore be it

RESOLVED, That our American Medical Association advocate for the federal legalization of interpharmacy transfers of valid electronic prescriptions for Schedule II-V medications. (New HOD Policy)

---


\(^3\) Office of the Professions. Frequently asked questions – Electronic transmittal of prescriptions in New York State. NYSED.gov. Available at: http://www.op.nysed.gov/prof/pharm/pharnelectrants.htm


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

Received: 05/02/18

RELEVANT AMA POLICY

Third Party Payers Mandating Doctor and Patient Transfers of Prescriptions H-120.927
Our AMA will advocate that: (1) insurers or other third party payers must provide 60 days advance notice of changes in retail pharmacy networks to both patients and all physicians treating these patients; (2) insurers or other third party payers making changes to their pharmacy network must allow patients to designate a new pharmacy of choice within the network; and (3) when an insurance company or other third party payer mandates prescription transfers due to a change in their retail pharmacy network, that the payer and pharmacies within network have mechanisms in place to seamlessly transfer the prescription, as initially prescribed with regard to refills, substitutions, and other pertinent prescription details, to the patients pharmacy of choice without the need for the patient/physician to initiate such transfer, as well as safety mechanisms to ensure that the formulation which has been established and tolerated is available to the patient without a lapse in dispensing.
Citation: Res. 701, A-17
Whereas, The cost of prescription drugs is increasing and now accounts for between 10-17% of national health care spending.\textsuperscript{1,2} As the ‘middlemen’ between patients, prescribers, and pharmacies, pharmacy benefit managers (PBMs) play an increasingly prominent role in the US health care system; and

Whereas, As the PBM industry has grown and consolidated over time, it has become more involved in the treatment of patients. The combined business of three PBM companies (CVS Caremark, Express Scripts and United Health’s Optum) control 85% of the entire US market.\textsuperscript{1} This includes essentially all Part D Medicare beneficiaries\textsuperscript{2}; and

Whereas, PBM companies have created access barriers which target patients, providers and pharmacies in the form of prior authorization requirements, step-therapy/fail first policies, specialty tiers, increased cost-sharing, non-medical drug switching, and other burdensome utilization management policies; and

Whereas, Providers have also expressed concerns with drug wastage, errors and the increasing time burden on their staff to find cost sharing assistance directly connected with PBM-policies; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) has taken notice and recently requested comments specifically on PBM practices in a proposed regulation on Medicare Advantage and Part D\textsuperscript{3}; and

Whereas, There are a number of bills before Congress and state legislatures to address the impact of PBMs on patient care and pharmacy or physician practice; and

Whereas, Contractual arrangements may not clearly outline the costs to providers and patients related to PBM policies. There are growing concerns about PBM’s imposition of direct and indirect remuneration (DIR) fees and clawbacks on pharmacies, which may be tied to quality metrics, despite not having appropriate measures in certain medical specialties\textsuperscript{4,5}; and

Whereas, PBMs have increasingly created barriers to physicians providing medication therapy management and dispensing drugs by directing/requiring patients to use pharmacies, including mail order pharmacies, owned by or associated with PBMs thereby negatively impacting patient care and access\textsuperscript{5}; and

Whereas, These concerns regarding PBM’s are significant and represent a potential threat to high quality patient care; therefore be it
RESOLVED, That our American Medical Association gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient’s timely access to medications, patient outcomes, and the physician-patient relationship (Directive to Take Action); and be it further

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

Fiscal Note: Estimated cost of $160,000 to implement resolution.

Received: 05/02/18


Whereas, Prostate Cancer is the third leading cause of death in American men behind Lung and Colorectal Cancer; and
Whereas, Screening for Breast Cancer and Colonoscopies are Covered Preventative Services for Patients without an annual deductible or co-pay; and
Whereas, New York introduced in 2017 legislation NY SB 6882/AB 8683 which calls for insurance coverage for Prostate Cancer screening without cost sharing to patients; and
Whereas, The American Urological Association recommends men age 55 to 69 years of age consider the benefits and harms associated with screening, and engage in shared decision making with their physician when considering PSA screening; and
Whereas, The American Medical Association has previously expressed support for the appropriate screening of prostate cancer (AMA Policy H-425.980); therefore be it
RESOLVED, That our American Medical Association develop model state legislation for screening of asymptomatic men ages 55-69 for prostate cancer after informed discussion between patients and their physician without annual deductible or co-pay. (Directive to Take Action)

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

Received: 05/02/18
RELEVANT AMA POLICY

Screening and Early Detection of Prostate Cancer H-425.980

Our AMA believes that:
(1) All men who would be candidates for and interested in active treatment for prostate cancer should be provided with information regarding their risk of prostate cancer and the potential benefits and harms of prostate cancer screening, sufficient to support well-informed decision making.
(2) Prostate cancer screening, if elected by the informed patient, should include both prostate-specific antigen testing and digital rectal examination.
(3) Men most likely to benefit from tests for early detection of prostate cancer should have a life expectancy of at least 10 years and include: (a) Men 40 years of age or older of African American descent; (b) Men 40 years of age or older with an affected first-degree relative; and (c) Men 50 years of age or older.

Citation: (CSA rep. 9, A-00; Modified: CSAPH Rep. 1, A-10)
Whereas, The three largest Pharmaceutical Benefit Managers (PBMs) now have more than 180 million customers and control approximately 80% of the U.S. market with combined operating profits of these three PBMs increasing from $3.4 billion in 2007 to $12.4 billion in 2016\(^1\); and

Whereas, The size of the manufacturer’s rebate to a PBM for some therapeutic classes may be 50% or more of the manufacturer’s list price, with the PBM retaining 10%, 15%, or more of the rebate as profit. Since the PBM will generate more profit as the manufacturer increases its list price, the business model has been widely cited as a contributor to the steady increase in prescription drug prices\(^1\); and

Whereas, U.S. pharmaceutical expenditures are $1,443 per capita versus $667 per capita in Germany with essentially the same drugs being available for the respective citizens with the difference being almost entirely due to higher drug prices in America\(^2\); therefore be it

RESOLVED, That our American Medical Association develop a set of principles for a National Prescription Drug Formulary (NPD Formulary) that are designed to lower prescription drug prices to the patient, and be transparent, independent, non-profit, and fee-based, with a report back to the AMA HOD at the 2018 Interim Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA produce model legislation for an NPD Formulary with input from appropriate stakeholders based on a set of principles for such a Formulary that the AMA will develop, and that our AMA join with appropriate stakeholders to advocate that Congress authorize the establishment of this NPD Formulary that will be available to all Americans as an option to their healthcare insurance program in an actuarially appropriate manner. (Directive to Take Action)

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

Received: 04/30/18

Whereas, There are significant numbers of physicians over the age of 55, and physicians in small group practices; and

Whereas, Small group practice physicians and more senior physicians are inherently encouraged to leave practice sooner given penalties imposed due to Medicare quality initiatives and;

Whereas, Participation in Medicare quality initiatives represent significant costs small group practices and to senior physicians particularly, and at a time when a physician shortage is increasingly evident; and

Whereas, The patient population has been expanded both by growth in the senior population, population growth in general, and greater accessibility, negative incentives will serve to drive physicians out of practice earlier at a time when they are most needed, and indeed represent a pool of experience and knowledge that is hard to duplicate; and

Whereas, Quality incentives in the payment system may, or may not be justifiable, in this instance they work against the system by narrowing the workforce both in terms of numbers and experience; and

Whereas, By eliminating penalties, by offering financial rewards for remaining in practice, some of that narrowing of the workforce may be mitigated; therefore be it

RESOLVED, That the American Medical Association work with the Department of Health and Human Services in incentivizing small groups, and more senior physicians, regardless of their volume of patients total billing in dollars, with “small group”, and “senior” deferments against penalties and bonuses for continued practice. (Directive to Take Action)

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

Received: 05/01/18

References:
RELEVANT AMA POLICY

Measurement of Drug Costs to Assess Resource Use Under MACRA H-385.911
1. Our AMA will work with Congress and the Centers for Medicare and Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System (MIPS) or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk, unless a Physician Focused Alternative Payment Model (incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory.
2. Our AMA will continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the MIPS payment adjustment as part of the Quality Payment Program (QPP).

MACRA and the Independent Practice of Medicine H-390.837
1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.
3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.

Protecting Patients Rights H-450.944
Our AMA opposes Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet our AMA's "Principles and Guidelines for Pay-for-Performance," which include the following five Principles: (1) ensure quality of care; (2) foster the patient/physician relationship; (3) offer voluntary physician participation; (4) use accurate data and fair reporting; and (5) provide fair and equitable program incentives.

Citation: Res. 218, A-16; Appended: Res. 225, I-17;
MACRA and the Independent Practice of Medicine H-390.837
Citation: Alt. Res. 206, A-17;
Protecting Patients Rights H-450.944
Citation: Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17;
Whereas, We are facing a shortage of physicians in this country and international medical graduates provide health care to millions of people in rural and underserved communities; and

Whereas, One in four physicians in the U.S. is an immigrant physician; and

Whereas, Immigrant physicians do not replace American workers, instead, we fill the missing gaps in U.S. healthcare, create more jobs, serve mostly the rural and underserved areas; and

Whereas, At the time of writing of the 2017 VA report by Office of Inspector General there continues to be a physician shortage in the VA hospital system that is most critical for Medical Officers; and

Whereas, The physician shortage has already affected multiple hospitals in the Veterans Affairs causing postponement of surgeries and challenges in providing timely care to Veterans; and

Whereas, There are physicians currently available in the United States to meet this shortage, such as the nearly 15,000 international medical graduates from India who are actively practicing in the U.S. stuck in the green card backlog waiting to get a green card, which may take up to 20 years at the current rate; and

Whereas, Physicians apply for green cards under the employment-based category 2 (EB2), which have more 20+ years for green card, causing multiple challenges, including unable to work at additional location, limited job opportunities and career advancements and unable to invest or start new businesses; therefore be it

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

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

Received: 05/01/18
RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.

Access to Health Care for Veterans H-510.985

Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans’ health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program’s “Choice Card” to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

Citation: Alt. Res. 308, A-17;

See also:
Expansion of US Veterans’ Health Care Choices H-510.983
Ensuring Access to Care for our Veterans H-510.986
Whereas, The World Health Organization\(^1\) defines the social determinants of health (SDOH) as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life; and

Whereas, These forces and systems include economic policies, development agendas, social norms, social policies and political systems; and

Whereas, Healthy People 2020 "highlights the importance of addressing the social determinants of health by including "create social and physical environments that promote good health for all"\(^2\); and

Whereas, Our American Medical Association (AMA) policies support efforts to ensure that individuals have access to safe, high-quality and patient-centered health care; and

Whereas, Our AMA adopted policy H-295.874,“Educating Medical Students in the Social Determinants of Health and Cultural Competence”; and

Whereas, Our AMA opposes polices and rules that would lead to barriers to access resources that are examples of SDOH such as housing applicants who consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance or Temporary Assistance for Needy (TANF) and work requirements for Supplemental Nutrition Assistance Program (SNAP); and

Whereas, The federal government is proposing budget cuts to the U.S. Department of Agriculture’s discretionary budget by $3.5 billion, or 15 percent by eliminating $17 billion in funds available to SNAP (food stamps); and

Whereas, The federal government seeks to cut more than $3 billion from the U.S. Department of Education; and

\(^1\) World Health Organization, [http://www.who.int/social_determinants/sdh_definition/en/](http://www.who.int/social_determinants/sdh_definition/en/), accessed March 22, 2018
Whereas, The federal government seeks to substantially reduce Section 8 federal housing subsidies, eliminate the $1.9 billion fund for public housing capital repairs, zero out community development block grants, discontinue grants to states and local governments to increase homeownership for the lowest-income Americans, and institute work requirements for individuals receiving housing subsidies; and

Whereas, The federal government seeks to decrease funding for National Dislocated Worker Grants -- support for those who lose their jobs in natural disasters or factory closures -- from $219.5 million in 2017 to $51 million in 2019; and

Whereas, The federal government seeks to decrease funding for Adult Employment and Training Activities, which serve veterans, Native Americans and young people who have dropped out of high school, by nearly half, from $810 million in 2017 to $490.3 million in 2019; and

Whereas, Our AMA seeks to maximize opportunities for collaboration among federal-, state-, and local-level partners related to social determinants of health; therefore be it

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

References:


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

Received: 05/02/18

RELEVANT AMA POLICY

Healthy Lifestyles H-425.972
1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

Citation: Res. 423, A-12; Appended: Res. 959, I-17;

See also:
Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Improvements to Supplemental Nutrition Programs H-150.937
Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
Whereas, Physicians are under extreme regulatory control when prescribing medications classified as "controlled"; and

Whereas, Any search of the internet will reveal hundreds of sites to purchase oxycodone, hydromorphone, and other controlled drugs without a prescription; and

Whereas, Selective androgen receptor modulators (SARM's) were not approved by the FDA because of lack of efficacy side effects, a recent web-based search found 44 products marketed and sold as SARM'S; and

Whereas, Of these 44 products when tested, 48% did not contain any of the advertised drug, 59% contained an amount different than what was on the label, and 91% contained other various combinations of other unapproved drugs including anabolic steroids, growth hormone secretagogues, and other nuclear hormone receptor modulators; and

Whereas, Many dietary supplements sold on the Internet contain hormones, drugs and known toxins very often not listed on the label; therefore be it

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

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

Received: 05/02/18

References:
Institute of Medicine (US) Committee on the use of Complementary and Alternative Medicine by the American Public, National Academies Press (US); 2005, Dietary Supplements.
Boghani, P., Can Regulators keep up with the Supplement Industry, pbs.org/wgbh/frontline/film/supplements.
Van Wagoner, R.M., et al, Chemical Composition and Labeling of Substances Marketed as Selective Androgen Receptor Modulators and Sold via the Internet, JAMA 2017; 318: 2004-2010’
Whereas, The provider-patient relationship is intimate and sacred; and

Whereas, Confidentiality of patient information is protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996; and

Whereas, HIPAA precludes sharing of patient information without the consent of the patient or their healthcare proxy; and

Whereas, Okla. Stat. Ann. tit. 13, § 176.4 states an individual who is a party to either an in-person conversation or electronic communication, or who has the consent of one of the parties to the communication, can lawfully record it or disclose its contents, unless the person is doing so for the purpose of committing a criminal or tortious act; and

Whereas, Recording in a public part of a doctor's office could violate other patients' privacy while making a recording in secret could both lead to a fundamental breach in the trust relationship between the health professional and the patient; and

Whereas, Open communication about the need for the recording will help ensure that recordings will not threaten the privacy of other patients and staff or affect the trust between physician and patient; and

Whereas, Twelve states have adopted laws specifically banning the use of video and still cameras where the subject has an expectation of privacy; therefore be it

RESOLVED, That our American Medical Association draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation. (Directive to Take Action)

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

Received: 05/01/18

References
Whereas, No one should go hungry; and

Whereas, Job loss, medical or family emergency, or temporary hardship has resulted in food insecurity for 632,030[1] individuals in Oklahoma, of which approximately 214,890[2] are children; and

Whereas, The Supplemental Nutrition Assistance Program (SNAP) helps alleviate food insecurity for Oklahoma families, children, elderly, and disabled and currently helps put food on the table for over 598,722[3] Oklahomans; and

Whereas, SNAP also has a positive economic impact in Oklahoma: every $1 spent in SNAP benefits puts $1.70 back into Oklahoma’s economy[4] and, in 2016 alone, Oklahoma SNAP retailers redeemed about $866 million[5] in SNAP benefits; and

Whereas, SNAP protects families, stimulates local economies, and supports Oklahoma’s farmers, ranchers, and businesses; and

Whereas, Increasing food insecurity results in increased chronic illness and subsequent higher healthcare costs[6] and leads further leads to worsened health outcomes[7], reduced workforce productivity, and poorer educational outcomes[8]; and

Whereas, According to the United States Department of Agriculture, there is only about 1.3% of waste, fraud, and abuse within the SNAP program, meaning 98.7% of recipients are meaningfully alleviated of food insecurity; and

Whereas, SNAP is a provision of the federal Farm Bill, which is up for reauthorization in 2018; therefore be it

RESOLVED, That our American Medical Association actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives (Directive to Take Action); and be it further

RESOLVED, That AMA Policy D-150.975, which calls for action to remove sugar-sweetened beverages from the Supplemental Nutrition Assistance Program, be reaffirmed (Reaffirm HOD Policy); and be it further
RESOLVED. That AMA Policy H-150.937, which in part aims to replace calorie-rich, nutrient-poor food with nutrient-dense food within the Supplemental Nutrition Assistance Program, be reaffirmed. (Reaffirm HOD Policy)

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

Received: 05/01/18


RELEVANT AMA POLICY

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer’s Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer’s Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer’s markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

Citation: Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17;

Eligibility of Sugar-Sweetened Beverages for SNAP D-150.975

Our AMA will: (1) publish an educational brief to educate physicians about the effects of sugar-sweetened beverages (SSBs) on obesity and overall health, and encourage them to educate their patients in turn, (2) encourage state health agencies to include educational materials about nutrition and healthy food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (SNAP) recipients along with the revised eligible foods and beverages guidelines, and (3) work to remove SSBs from SNAP.

Citation: (Res. 238, A-13; Reaffirmation A-14)
Whereas, The Primary Care Enhancement Act (H.R. 365 and S. 1358) is a bipartisan bill which expands access to high-functioning primary care services for Americans of all income and age levels. The legislation clarifies to the tax code to remove a major federal regulatory barrier keeping patients, providers and employers who use Health Savings Accounts (HSAs) from using innovative Direct Primary Care (DPC) medical homes to improve health outcomes and reduce costs; and

Whereas, Internal Revenue Service (IRS) rules prohibit individuals with HSAs paired with high deductible health plans (HDHPs) from having an agreement with a DPC provider; and

Whereas, The IRS incorrectly interprets DPC arrangements as health plans under Section 223(c) of the Internal Revenue Code; furthermore IRS says the law is unclear whether or not primary care services are qualified health expenses under Section 213(d) of the code, if services are paid for with a capitated periodic fee rather than fee for service; and

Whereas, The Primary Care Enhancement Act clarifies the tax code, making it clear that patients with HSAs paired with HDHPs have access to great primary care with a DPC medical home; and

Whereas, Department of Health and Human Services (HHS) regulations already define DPC medical homes as primary care services – HHS rules note that they are an important delivery reform being defined in state laws; and

Whereas, Current IRS policy inappropriately interprets DPC arrangements as a form of health plan--despite other interpretations in state and federal law; and

Whereas, As long as IRS interprets DPC as a health plan, simply having an agreement with a DPC provider bars an individual from funding an HSA; and

Whereas, IRS rules also need to be clarified to allow fees for periodic fee-based DPC to be paid for using HSA funds; and

Whereas, IRS regulations are clear: HSAs must be paired with an HDHP, and the HSA holder may not have a second health plan; and

Whereas, Twenty-three states have enacted statutes defining DPC outside of state insurance regulation and many others offer guidance which concurs that DPC Medical Homes are medical services, not health plans; and
Whereas, DPC is currently offered in exchanges, with self-insured employers, unions, in
Medicare Advantage and Medicaid MCOs; and

Whereas, Individuals with HSAs are the only people with health coverage who are barred by
federal regulations from having a DPC provider; therefore be it

RESOLVED, That our American Medical Association, pursuant to H-385.912, actively lobby
Congress to pass the Primary Care Enhancement Act. (Directive to Take Action)

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

Received: 05/01/18

RELEVANT AMA POLICY

Direct Primary Care H-385.912
Our AMA supports inclusion of Direct Primary Care as a qualified medical expense by the
Internal Revenue Service.
Citation: Res. 103, A-16
Whereas, Hospital consolidation has increased substantially over the last 5 years and as many as 20% of all US hospitals will seek a merger in the next 5 years; and

Whereas, None of the geographic health care markets in the US are considered “highly competitive,” and 90 percent of metropolitan areas have highly concentrated hospital markets;¹ and

Whereas, Highly concentrated hospital markets increase hospital prices, reduce choice, and reduce physician practice options;² and

Whereas, The market power of hospital conglomerates in many, if not most, geographic health care markets far exceeds health insurance plans’ market power resulting in excessive hospital cost inflation; and

Whereas, Conglomerate chain hospitals can make decisions about the regional care offerings without respect for the individual patient’s preferences; and

Whereas, Hospital rate setting commissions, like in Maryland, can reduce total expenditures and excessive hospital cost inflation without shifting costs to other parts of the health care system;³ therefore be it

RESOLVED, That our American Medical Association actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets (New HOD Policy); and be it further

RESOLVED, That our AMA study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist. (Directive to Take Action)

REFERENCES
² CMS Rep. 5, A-17

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

Received: 05/02/18
RELEVANT AMA POLICY

Specialty Hospitals and Impact on Health Care H-215.968
Our AMA supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care.
Citation: BOT Rep. 15, I-04; Reaffirmation A-09; Reaffirmed: CMS Rep. 05, A-17
Whereas, The Medicare Payment Advisory Commission (MedPAC) announced a proposal to drop the Merit-Based Incentive Payment System (MIPS) program in its annual report to Congress on needed changes to Medicare payment policies (March 2018); and

Whereas, MedPAC commissioners have concluded that MIPS will not fulfill its goals and therefore should be replaced with a voluntary value program (VVP) whereby clinicians would not have to report quality data themselves; and

Whereas, Our AMA has policy advocating for an exemption from MIPS and Medicare Acess and CHIP Reauthorization Act of 2015 (MACRA) for small practices (AMA Policy H-390.838); and

Whereas, Our AMA has longstanding policy encouraging the Centers for Medicare and Medicaid Services to revise MIPS to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care (H-390.837); therefore be it

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

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

REFERENCES
March 2018 MEDPAC Report to the Congress: Medicare Payment Policy; Chapter 15: Moving Beyond the Merit-Based Incentive Payment System http://www.medpac.gov/-documents-/reports

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

Received: 05/02/18

RELEVANT AMA POLICY
Measurement of Drug Costs to Assess Resource Use Under MACRA H-385.911
1. Our AMA will work with Congress and the Centers for Medicare and Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System (MIPS) or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician’s performance and assumption of financial risk, unless a Physician Focused
Our AMA will advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS). Citation: Res. 104, A-16; Based Incentive Payment System (MIPS).

Our AMA supports that the "Triple Aim" be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers. Support for the Quadruple Aim H-405.955 Citation: BOT Rep. 10, A-16; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmed in lieu of: Res. 712, A-17.

Our AMA will continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the MIPS payment adjustment as part of the Quality Payment Program (QPP). Citation: Res. 218, A-16; Appended: Res. 225, I-17;

Physician Payment Reform H-390.849
1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
   a) promote improved patient access to high-quality, cost-effective care;
   b) be designed with input from the physician community;
   c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
   d) not require budget neutrality within Medicare Part B;
   e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
   f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
   g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
   h) use adequate risk adjustment methodologies;
   i) incorporate incentives large enough to merit additional investments by physicians;
   j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
   k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
   l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
   m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.
Citation: CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation A-16; Reaffirmed in lieu of: Res. 712, A-17;

Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) D-390.950
1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.
Citation: Res. 242, A-16;

MIPS and MACRA Exemption H-390.838
Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.
Citation: Res. 208, I-16; Reaffirmation: A-17; Reaffirmation: I-17;

Electronic Health Records and Meaningful Use D-478.971
Our AMA: (1) will continue to work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to allow for partial credit for eligible professionals in the Meaningful Use and Merit-Based Incentive payment programs; and (2) will compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions.
Citation: BOT Rep. 10, A-16;

Support for the Quadruple Aim H-405.955
1. Our AMA supports that the "Triple Aim" be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
2. Our AMA will advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS).
Citation: Res. 104, A-16;
Whereas, E-prescribing is a process enabled by electronic medical records (EMRs) that gets widespread support as a benefit of the EMR for patient safety and provider process benefit, and

Whereas, The process for e-prescribing was designed in large part by automating preexisting paper, voice and fax processes; and

Whereas, E-prescriptions are sent from prescriber systems to a central clearinghouse to resolve formulary and other issues prior to dispensing, and

Whereas, The goal should be a strategically designed efficient process that allows each participant to perform the roles they must perform and not perform those they don't need to perform while leveraging evolving technology; and

Whereas, Good processes can always be made better; and

Whereas, E-prescribing makes the process of obtaining refills less cumbersome for prescriber and patient alike, making e-prescribing of controlled substances a significant opportunity for physicians to fight the opioid crisis by prescribing smaller initial amounts of opioid medications; and

Whereas, The current cumbersome requirement for two-factor authentication to e-prescribe controlled substances has tragically delayed widespread adoption of e-prescribing for controlled substances; and

Whereas, Widespread adoption of e-prescribing for controlled substances would make physician contributions to this problem and its solutions more transparent and accountable; and

Whereas, Using the same process for prescribing controlled substances as for all other medications deserves consideration as the alternative to doing the same thing we are doing and expecting a different result; and

Whereas, Making it easier to do the right thing will make it more likely the right thing will be done; and

Whereas, The steps requiring the expertise and license of the physician include the choice of drug, form, dose, instructions, duration and refills; and
Whereas, Prescriber expertise is not required to designate which pharmacy should ultimately fill the prescription when the prescription is e-prescribed using a nationwide clearinghouse (in most cases Surescripts); and

Whereas, Patients could authorize the pharmacy of their choice to retrieve the information needed to fill a prescription from the clearinghouse rather than involving the physician or staff in the error-prone choice of pharmacy, particularly when the pharmacy is outside the prescriber’s community; and

Whereas, Patients could authorize the physician to send their prescription directly to a specific specialty or compounding pharmacy (bypassing the clearinghouse) for purposes of improved quality or accessibility for patient benefit; therefore be it

RESOLVED, That our American Medical Association study current e-prescribing processes and make recommendations to improve these processes to make them as safe as possible for patients and as efficient as possible for prescribers. (Directive to Take Action)

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

Received: 05/02/18
Whereas, Direct and indirect costs of pharmaceuticals continue to grow disproportionately (accounting for almost 60% of the cost for the most expensive chronic disease diabetes mellitus, for instance\(^1\)), even while the market approaches 90% generic; and

Whereas, The growth of pharmacy-benefit interference is a major source of complaints by both patients and physicians, and unequivocally interferes with the clinical primacy of the patient-physician relationship; and

Whereas, These manipulations are interfering daily with the efficient practice of American medicine without effectively constraining the rate of growth of pharmaceutical costs; and

Whereas, Over 30 years of pharmaceutical market evolution under the Hatch-Waxman Act has allowed for perverse price discrepancies between the newest agents and popular generics, incentivized "me-too" drug development and patent-extending alterations, and created a generic market with uneven competition (co-existence of very inexpensive markets [with possible manufacturing quality implications], intermittent shortages, and unexpected cost increases for rare drugs); and

Whereas, Any change in pharmaceutical pricing policy and regulation must seek to balance incentives for innovation in addition to rewards for value delivered; therefore be it

RESOLVED, That our American Medical Association support federal legislation that modifies the Hatch-Waxman Act and the Biologics Price Competition and Innovation Act (Biosimilars Act) to institute the replacement of time-specific patent protections with negotiated payment schedules and indefinite exclusivity for U.S. Food and Drug Administration-approved drugs in the Medicare Part D Program. (New HOD Policy)


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

Received: 05/02/18
Whereas, The opioid epidemic has become a critical threat to public health in the U.S.¹; and

Whereas, Hospitalizations have been rapidly increasing for opioid overdose and for infectious complications of injection drug use such as hepatitis C, HIV, and deep tissue bacterial infections, reaching 1.27 million emergency room and inpatient stays in 2014²; and

Whereas, Inpatient costs among those with opioid use disorder almost quadrupled to $15 billion between 2002 and 2012³; and

Whereas, There is a high risk of repeated hospitalization⁴ and overdose death following hospitalization due to loss of opioid tolerance⁵, but hospitals rarely address the underlying chronic disease of opioid use disorder⁶,⁷; and

Whereas, FDA-approved medications for treating opioid use disorder (buprenorphine, methadone and naltrexone) reduce illicit opioid use¹; opioid agonist therapy (buprenorphine or methadone) reduces opioid overdose death by 50%⁶ in part by preventing loss of opioid tolerance; and buprenorphine provides further protection because of its high receptor affinity and ceiling effect on respiratory depression⁸; and

Whereas, Initiation of buprenorphine in the emergency department⁹ and inpatient setting¹⁰ and linkage to ongoing comprehensive treatment as an outpatient is an effective means for engaging patients and reducing illicit opioid use¹¹-¹³, therefore be it

RESOLVED, That our American Medical Association adopt a policy in favor of hospitals in the United States treating opioid use disorder with medications approved by the U.S. Food and Drug Administration for that purpose (buprenorphine, methadone and naltrexone) along with appropriate counseling (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for legislation, standards, policies and funding to support hospitals in the United States treating opioid use disorder with medications approved by the FDA for that purpose (buprenorphine, methadone and naltrexone) along with appropriate counseling (New HOD Policy); and be it further

RESOLVED, That our AMA work together with relevant organizations such as the American Hospital Association, The Joint Commission and the American Society of Addiction Medicine to develop and promote a model hospital policy that would assist hospitals in addressing opioid use disorder as a chronic disease by:

a) ensuring that medical and other clinical staff are educated about evidence-based treatment of opioid use disorder in order to appropriately advise and treat their patients,

b) providing patient education about and access to all three FDA-approved medications (buprenorphine, methadone and naltrexone) in emergency and inpatient settings, and buprenorphine and methadone in obstetric settings,

c) maintaining use of these medications for patients already on them,

d) initiating use of these medications for assenting patients affected by the disease,

e) establishing comprehensive discharge plans for ongoing medical and behavioral treatment in the community, and

f) participating in the development of community-wide systems of care for patients with opioid use disorder to facilitate discharge planning. (Directive to Take Action)

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

Received: 05/02/18
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(A-18)

Introduced by: Illinois

Subject: Treating Opioid Use Disorder in Treatment Facilities

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, The opioid epidemic has become a critical threat to public health in the U.S.¹; and
Whereas, Only 10 percent of individuals in the U.S. with an opioid use disorder obtain treatment¹; and
Whereas, Less than half of facilities that provide inpatient treatment for opioid use disorder offer an FDA-approved medication for opioid use disorder²³; and
Whereas, The risk of a fatal overdose increases 25-fold in the month immediately after inpatient treatment of opioid use disorder without medication⁴, in part due to loss of opioid tolerance⁵; and
Whereas, Opioid overdose death is reduced by 50% by treatment with opioid replacement therapy (buprenorphine or methadone)⁶, which prevents loss of opioid tolerance; and
Whereas, The U.S. Food and Drug Administration is pursuing strategies to eliminate barriers and promote access to all effective medications known to address opioid use disorder at state-certified opioid treatment programs; and
Whereas, The President’s Commission on Combating Drug Addiction and the Opioid Crisis recommended a requirement that all three FDA-approved medications (buprenorphine, methadone and naltrexone) be available at every facility licensed to treat opioid use disorder⁷, and clinical guidelines indicate that the choice of treatment options should be a shared decision between the clinician and the patient⁸; therefore be it

References:
RESOLVED, That our American Medical Association adopt a policy that recognizes the use of buprenorphine or methadone as effective treatment for opioid use disorder, and encourages the appropriate use of medication and non-medication-based treatment (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for legislation to eliminate barriers and require access to all three FDA-approved medications (buprenorphine, methadone and naltrexone) at all legally certified drug treatment facilities, and advocate for standards, policies and funding to support access to these medications at treatment facilities (New HOD Policy); and be it further

RESOLVED, That our AMA conduct a campaign to increase awareness on the part of providers, treatment programs, and the public that AMA recognizes the use of buprenorphine or methadone as effective treatment for opioid use disorder. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/02/18
Whereas, U.S. federal law requires drug and device companies to report compensation to physicians as part of the Physician Payments Sunshine Act; and

Whereas, These compensations are listed on a public website named OpenPaymentsData.CMS.gov and can be searched by an individual physician’s name; and

Whereas, Companies that report physician compensation do not have to provide proof of delivery and receipt of reportable compensation; and

Whereas, Companies’ representatives may leave food, beverages, or other gifts at a physician’s office (or at the door of the office) without physician consent and report this “gift” under the Sunshine Act; and

Whereas, Disputing a payment that has been inaccurately reported by a company is cumbersome and requires the reporting company to submit paperwork redacting the payment; and

Whereas, Payment posted in error may imply a conflict of interest or relationship between the physician and the company to the public, including the physician’s patients; therefore be it

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

RESOLVED, That our AMA advocate that contested reported compensation should be removed immediately from the OpenPaymentsData.CMS.gov website until the reporting company validates the compensation with a signed receipt (New HOD Policy); and be it further

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

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

Received: 05/02/18
Whereas, Compounding pharmacies tailor and customize prescriptions to meet patients' needs for medications that are not commercially available; and

Whereas, Many of these patients have problems with mass-produced medications including allergic reactions, inability to swallow pills, or a need for a different dosage or formulation than is available on the commercial market; and

Whereas, Compounding pharmacies must have federal certification as a result of the Drug Quality and Security Act enacted in 2013; and

Whereas, Compliance with this Act by compounding pharmacies requires acceptable manufacturing practices, proper labeling including directions for use, inspections of these pharmacies by the U.S. Food and Drug Administration (FDA) on a regular basis, and FDA approval prior to marketing compounding medications; and

Whereas, Pharmacy benefit managers (PBMs) are hired by employers to manage their employee prescription drug coverage; and

Whereas, PBMs control the drug benefits of 210 million Americans of which 28 million are Medicare Part D patients; and

Whereas, The largest PBMs in the U.S. include Express Scripts, CVS Caremark, Optum Rx, Argus, EnvisionRx, ProCareRX, and Prime Therapeutics; and

Whereas, At the heart of the conflict between PBMs and compounding pharmacies is the fact that PBMs have used their position and power as health plan administrators to boycott compounding pharmacies by eliminating coverage for compounding ingredients, cutting off health network access, and devising various “gate keeper tactics” using unreasonable administrative mandates designed to deny prescriptions from being filled; and

Whereas, Their intent is to cause a significant decline and potential elimination of independent compounding pharmacies from the health plan market; and

Whereas, PBMs have a conflict of interest in their gatekeeper role as they own a financial stake in a mail order business that competes with compounding pharmacies that use the U.S. Postal Service, UPS, and other delivery systems; and

Whereas, PBMs maintain that spending on compound medications has increased exponentially; and
Whereas, Their solution to address these rising costs is to target and block thousands of ingredients used by compounding pharmacies that they claim are greatly inflated but provide no added clinical benefit; and

Whereas, One needs to question whether PBMs are qualified to evaluate clinical benefit or is it just part of their financial agenda in the $270 billion drug market; and

Whereas, PBMs have sent letters to patients and pharmacies containing inaccurate and misleading information about the safety and efficacy of compound medications. These letters to patients inform them there has been an unspecified change in their compound medication benefit plan although PBMs lack the authority to alter the terms of patient health care plans. These documents serve to cover up the financially driven scheme of PBMs to cut their compound spending by 95 percent; and

Whereas, This scheme has resulted in denial of care to thousands of patients as PBMs continue to issue unlawful blanket denials of compounded medications; and

Whereas, PBMs have engaged in retroactive audits of compounding pharmacies to claim back reimbursements for compounded scripts already filled citing the lack of FDA approval of the medications; and

Whereas, They have removed compounding pharmacies from provider networks by terminating agreements without just cause and often without knowledge of these compounding pharmacies; and

Whereas, PBMs have also threatened some physicians with accusations of fraud or abuse if they prescribe compounded medications; and

Whereas, As a result of their anti-competitive conduct, PBMs have continued to “line their pockets” financially at the expense of the most vulnerable patients in America; therefore be it

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

Pharmaceutical Benefits Management Companies H-125.986
Our AMA: (1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;
(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care; and

(6) supports Congressional action to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications, and encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest. (Modify Current HOD Policy)

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

Received: 05/02/18

RELEVANT AMA POLICY

Pharmaceutical Benefits Management Companies H-125.986
Our AMA: (1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;

(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers’ influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;

(3) pursues Congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;

(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients; and

(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care.

Citation: BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533; A-03; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: Alt. Res. 806, I-17;
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-18)

Introduced by: Michigan

Subject: Report Health Care Provider Sex Crimes to Law Enforcement

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, High profile cases of health care provider sexual abuse and assault of patients have increased public awareness of this issue; and

Whereas, Public outcry is justly critical of an opaque system that protects and shields abusers from justice, allowing abuse to continue; and

Whereas, The process to report health care provider sexual abuse and assault of patients is confusing for victims and colleagues and the legal definition of criminal sexual conduct is often poorly understood; and

Whereas, Victims and reporting colleagues of the accused may not realize a crime has occurred or may assume that reports to the board of medicine will also trigger a criminal investigation; and

Whereas, Not all states permit or require their licensing boards to report suspected sex crimes to the police; and

Whereas, Eleven states (AZ, DE, FL, IA, OR, MA, MD, NY, TN, TX, WA) have such a provision in their public health codes, to not only allow reporting to law enforcement but to mandate it; and

Whereas, This loophole has allowed health care providers across the country to commit sex crimes against patients with only medical sanctions, revocation of their licenses, or “quiet retirement” without facing criminal charges for their actions; therefore be it

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

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

Received: 05/02/18
RELEVANT AMA POLICY

Physician Competence H-275.998
Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.)


E-9.4.3 Discipline & Medicine
Incompetence, corruption, dishonest, or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the public's confidence in the profession. The obligation to address misconduct falls on both individual physicians and on the profession as a whole. The goal of disciplinary review is both to protect patients and to help ensure that colleagues receive appropriate assistance from a physician health program or other service to enable them to practice safely and ethically. Disciplinary review must not be undertaken falsely or maliciously.

Individually, physicians should report colleagues whose behavior is incompetent or unethical in keeping with ethics guidance. Collectively, medical societies have a civic and professional obligation to:
(a) Report to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine. 
(b) Initiate disciplinary action whenever a physician is alleged to have engaged in misconduct whenever there is credible evidence tending to establish unethical conduct, regardless of the outcome of any civil or criminal proceedings relating to the alleged misconduct.
(c) Impose a penalty, up to and including expulsion from membership, on a physician who violates ethical standards.

AMA Principles of Medical Ethics: II,III,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. Issued: 2016
Reference Committee C

CME Report(s)
01 Council on Medical Education Sunset Review of 2008 House of Delegates Policies
02 Update on Maintenance of Certification and Osteopathic Continuous Certification
03 Expanding UME Without Concurrent GME Expansion
04 Evaluation of Clinical Documentation Training
06 Mental Health Disclosures on Physician Licensing Applications

Resolution(s)
301 Protecting Medical Trainees from Hazardous Exposure
302 For-Profit Medical Schools or Colleges
303 Fellowship Start Date
304 Persons With Intellectual and Developmental Disabilities Designated as a Medically Underserved Population
305 Standardization of Medical Licensing Time Limits Across States
306 Sex and Gender Based Medicine
307 Healthcare Finance in the Medical School Curriculum
308 Foreign Trained IMGs Obtaining a U.S. License Without U.S. Residency
309 Foreign Trained IMGs Competency-Based Specialty Exam Without U.S. Residency
310 U.S. Institutions With Restricted Medical Licensure
311 Opioid Education for New Trainees
312 Suicide Awareness Training
313 Financial Literacy for Medical Students and Residents
314 Board Certification Changes Impact Access to Addiction Medicine Specialists
315 Peer-Facilitated Intergroup Dialogue
316 End "Part 4 Improvement in Medical Practice" Requirement for ABMS MOC
Subject: Council on Medical Education Sunset Review of 2008 House Policies

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee C
(Sherri S. Baker, MD, Chair)

AMA Policy G-600.110, “Sunset Mechanism for AMA Policy,” is intended to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations. The current policy reads as follows:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.
The Council on Medical Education’s recommendations on the disposition of the 2008 House policies that were assigned to it are included in the Appendix to this report. Due to their complexity, and the need for a more thorough consolidation of policy than is available through the sunset report mechanism, the following policies will be addressed in a Council on Medical Education report(s) at the 2018 Interim Meeting:

- H-200.956, “Appropriations for Increasing Number of Primary Care Physicians”
- H-200.966, “Federal Financial Incentives and Medical Student Career Choice”
- H-200.973, “Increasing the Availability of Primary Care Physicians”
- H-200.977, “Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians”
- H-200.978, “Loan Repayment Programs for Primary Care Careers”
- H-200.997, “Primary Care”
- H-295.956, “Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers”
- H-310.979, “Resident Physician Working Hours and Supervision”
- H-310.999, “Guidelines for Housestaff Contracts or Agreements”
- D-305.970, “Proposed Revisions to AMA Policy on Medical Student Debt”
- D-305.978, “Mechanisms to Reduce Medical Student Debt”
- D-305.980, “Immediate Legislative Solutions to Medical Student Debt”

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.
APPENDIX
RECOMMENDED ACTIONS ON 2008 AND OTHER OR RELATED HOUSE OF DELEGATES POLICIES

<table>
<thead>
<tr>
<th>Policy Number, Title, Policy</th>
<th>Recommended Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H-200.975, “Availability, Distribution and Need for Family Physicians”</strong></td>
<td>Sunset; superseded by H-200.973, “Increasing the Availability of Primary Care Physicians”; relevant segments include:</td>
</tr>
<tr>
<td></td>
<td>(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective.</td>
</tr>
<tr>
<td></td>
<td>(5) All four years of the curriculum in every medical school should provide experiences in primary care for all students….</td>
</tr>
<tr>
<td></td>
<td>(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians.</td>
</tr>
<tr>
<td></td>
<td>(9) There should be increased financial incentives for physicians practicing primary care.</td>
</tr>
<tr>
<td></td>
<td>(10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate “hassle” and unnecessary paper work should be undertaken.</td>
</tr>
<tr>
<td></td>
<td>(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas.</td>
</tr>
<tr>
<td></td>
<td>(12) States should be encouraged to provide positive incentives—such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities—to support medical students’ choice of a primary care specialty. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.</td>
</tr>
</tbody>
</table>

| The AMA will include the International Medical Graduates Section as a resource for international medical initiatives. (Res. 608, A-98; Reaffirmed: CLRPD Rep. 1, A-08) |
H-255.980, “USMLE Scores not Sole Criteria for Residency Selection”

Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates’ attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicants merit and qualifications. Citation: Res. 143, A-90; Appended Res. 303, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Modified: Speakers Rep. 01, A-17

Retain; still relevant.

H-275.937, “Patient/Physician Relationship and Medical Licensing Boards”

(1) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are: (a) Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care. (b) Commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician’s personal interests. (c) Provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more nor less. (d) Avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship.

(2) The relationship between a physician and a patient is fundamental and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship.

(3) Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being

Retain; still relevant, with the editorial change shown below:

(1) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: (1) . . . .

(4) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: (1) . . . .
found in violation of the Medical Practice Act.
(4) The following statement reflects the policy of the (name of state) Board of Medical Examiners regarding the physicians it licenses.
(5) A (name of state) physician has both medical-legal and ethical obligations to his or her patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician’s ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients. (BOT Rep. 30, I-98; Reaffirmed: CME Rep. 2, A-08)

H-275.938, “USMLE Part III and Licensure”

<table>
<thead>
<tr>
<th>Our AMA will lobby the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take the USMLE Part III. (Res. 325, A-98; Reaffirmed: CME Rep. 2, A-08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retain, still relevant, with the following editorial changes: Our AMA will lobby advocate to the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take the USMLE Part III.</td>
</tr>
</tbody>
</table>

H-275.957, “Changing the Grading Policy for Medical Licensure Examinations”

<table>
<thead>
<tr>
<th>Our AMA is concerned about the potential for inappropriate use of numerical scores of licensing examinations, particularly as a significant criterion in appointment to residency training programs. Past studies show some residency programs inappropriately use USMLE examination scores in screening their applicants. Our AMA supports the development of mechanisms to ensure confidentiality of the results of licensure exams, and that these results are used only in an appropriate fashion. (BOT Rep. GGG, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CME Rep. 2, A-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunset; superseded by H-275.980, “USMLE Scores not Sole Criteria for Residency Selection,” as follows: Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates’ attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicants merit and qualifications.”</td>
</tr>
</tbody>
</table>

H-275.968, “Recredentialing of Physicians”

<table>
<thead>
<tr>
<th>The AMA vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration. (Res. 201, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retain through incorporation into H-275.978, “Medical Licensure,” as follows: (23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration.</td>
</tr>
</tbody>
</table>
The AMA supports the Federation of State Medical Boards’ efforts to assure that organizations that use the Federation’s copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards. (Sub. Res. 126, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)

<table>
<thead>
<tr>
<th><strong>H-275.972, “Annual Report of Disciplinary Actions from the Federation of State Medical Boards”</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The AMA supports the Federation of State Medical Boards’ efforts to assure that organizations that use the Federation’s copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards. (Sub. Res. 126, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)</td>
</tr>
<tr>
<td>Retain through incorporation into H-275.978, “Medical Licensure,” to read as follows:</td>
</tr>
<tr>
<td>(24) supports the Federation of State Medical Boards’ efforts to assure that organizations that use the Federation’s copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards.</td>
</tr>
</tbody>
</table>

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions | Revise to incorporate the following relevant policies that are being appended to this policy: H-275.968, “Recredentialing of Physicians” H-275.972, “Annual Report of Disciplinary Actions from the Federation of State Medical Boards.” |

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

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and

(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.


of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;

(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and

(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license;

(23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration; and

(24) supports the Federation of State Medical Boards’ efforts to assure that organizations that use the Federation’s copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that
comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards.

### H-275.981, “Education in the Professional Discipline Process”

| The AMA (1) urges all state medical associations to recommend that each medical school in its state invite members of the state agency in charge of professional medical conduct to lecture on the topic of professional discipline; and (2) urges each state medical association to recommend that each hospital in its state with a training program invite a member of the state agency in charge of professional medical conduct to disseminate to its housestaff information on the workings of the professional discipline agency. (Res. 8, I-86; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08) | Retain; still relevant. |

### H-295.869, “Student Loan Empowerment”

| Retain through incorporation into D-305.993, “Medical School Financing, Tuition, and Student Debt,” to read as follows:  

1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection and loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.  

2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical |
research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts.

3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.

Our AMA supports a requirement that medical schools inform students of all government loan opportunities along with private loans, and requires disclosure of reasons that preferred lenders were chosen. (Res. 307, A-08)

5. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.

6. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians.

7. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.

8. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.

9. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the
Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.

Our AMA will advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility.

Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

H-295.892, “Potential Implications of Attending Non-LCME/AOA Accredited Medical Education Programs”

Our AMA encourages efforts to educate all prospective medical students about the potential implications of attending any non-Liaison Committee on Medical Education/American Osteopathic Association accredited medical education program. (Res. 322, I-98; Reaffirmed: CME Rep. 2, A-08)

Sunset; superseded by D-295.309, “Promoting and Reaffirming Domestic Medical School Clerkship Education,” which reads in part: “4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.”
### H-295.893, “Voting Rights for AMA-MSS NBME Representatives”

Our AMA will: (1) petition the National Board of Medical Examiners (NBME) to add AMA student representation to the National Board, the governing and voting body of the NBME; and (2) work with the NBME to ensure that the AMA-MSS, through its Governing Council, is given appropriate advance notice of any major upcoming votes. (Res. 323, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 10, A-08)

Sunset; no longer relevant, as this has been accomplished.

### H-295.894, “Medical Education on Sleep and Sleep Disorders”

Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education. (Res. 310, I-98; Reaffirmed: CME Rep. 2, A-08)

Retain; still relevant.


Principles to guide exemption of medical students from activities based on conscience include the following:

1. Medical schools should address the various types of conflicts that could arise between a physician’s individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues.
2. Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students’ religious or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity.
3. Prospective students should be informed prior to matriculation of the school’s policies related to exemption from activities based on conscience.
4. There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies.
5. Policies related to exemption based on conscience should be applied consistently.
6. Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any
exceptions to this principle should be explicitly described by the school.

<table>
<thead>
<tr>
<th>(7) Patient care should not be compromised in permitting students to be excused from participating in a given activity. (CME Rep. 9, I-98; Reaffirmed: CEJA Rep. 11, A-08)</th>
</tr>
</thead>
</table>

### H-295.902, “Alternative Medicine”

| (1) AMA policy states that courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities. (2) Our AMA will work with members of the Federation to convey physicians’ and patients’ concerns and questions about alternative care to the NIH Office of Alternative Medicine and work with them and other appropriate bodies to address those concerns and questions. (CSA Rep. 12, A-97; Appended by Res. 525, A-98; Reaffirmed: CSAPH Rep. 2, A-08) |
| Retain; still relevant. |

### H-295.972, “Education Regarding Prescribing Controlled Substances”

| The AMA (1) encourages physicians, hospital medical staff organizations, resident physicians, and medical students to participate in education programs to ensure proper prescribing and dispensing of controlled substances; and (2) encourages regulatory agencies, state medical societies, and state medical boards to recognize the value of participation in such educational programs as an alternative to imposing disciplinary sanctions on well-intentioned physicians. (Sub. Res. 76, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08) |
| Retain; still relevant. |

### H-295.993, “Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs”

| Our AMA: (1) recognizes the need for (a) appropriate mechanisms to include medical students and resident physicians in existing medical society impaired physician programs; and (b) these programs to include activities to prevent impairment; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available medical school impairment treatment programs and that schools |
| Sunset; superseded by H-295.863, “Impairment Prevention and Treatment in the Training Years,” which reads: “Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with |
ensure that these services are provided confidentially. (Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08)

confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians.” (CCB/CLRDPD Rep. 3, A-14)

H-295.999, “Medical Student Support Groups”

Retain through incorporation into H-295.858, “Access to Confidential Health Services for Medical Students and Physicians,” as follows:

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees’ grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider
designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept “safe haven” non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
   A. be available to all medical students on an opt-out basis;
   B. ensure anonymity, confidentiality, and protection from administrative action;
   C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
   D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the
presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty.


6) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

| **H-305.938, “Use of Social Security Numbers in Student Loan Accounts”** |
|-------------------|-------------------|
| Our AMA will work with student loan servicers and other associated agencies to end the use of Social Security Numbers as account numbers. (Res. 302, I-98; Reaffirmed: CME Rep. 2, A-08) | Retain; still relevant. |

| **H-310.935, “The Educational and Work Environment of Resident Physicians”** |
|-------------------|-------------------|
| AMA policy is that there should be resident organizations in place at institutions that sponsor graduate medical education programs to facilitate the ability of residents to negotiate about issues related to their working environment. (CME Rep. 11, A-98; Reaffirmed: CME Rep. 2, A-08) | Retain; although the Accreditation Council for Graduate Medical Education has related policy in its Institutional Requirements, the AMA needs to have policy that addresses the need for residents to be able to negotiate on issues related to their working conditions. |
Our AMA reaffirms the inclusion of ambulatory care settings and the participation of community hospitals in graduate medical education. (CME Rep. A, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation I-08)

<table>
<thead>
<tr>
<th>H-310.967, “Resident Training in Varied Settings”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunset; superseded by H-310.929, “Principles for Graduate Medical Education,” which reads in part:</td>
</tr>
<tr>
<td>“(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.”</td>
</tr>
<tr>
<td>Also reflected in H-305.929, “Proposed Revisions to AMA Policy on the Financing of Medical Education Programs,” which reads in part:</td>
</tr>
<tr>
<td>“H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.”</td>
</tr>
<tr>
<td>Also reflected in H-295.949, “Encouraging Community Based Medical Education,” which reads: “Our AMA recognizes and acknowledges the vital role of practicing physicians in community hospitals in medical student and resident teaching.”</td>
</tr>
<tr>
<td>Also reflected in The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967 (26), which reads: “Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.”</td>
</tr>
</tbody>
</table>
### H-310.973, “Primary Care Residencies in Community Hospitals”

Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs.

(Sub. Res. 27, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-08)

| Retain; still relevant. |

### H-315.982, “CMS Documentation Guidelines for Teaching Physicians”

The AMA will work with the CMS to: (1) reduce the redundant and burdensome documentation for teaching physicians; (2) accept documentation by the physician team under the supervision of a teaching physician if it collectively meets all CMS documentation requirements; and (3) accept a statement of the teaching physician’s level of participation in patient care as sufficient or adequate documentation.

(Res. 861, A-98; Reaffirmed: CME Rep. 2, A-08)

| Retain; still relevant. |

### H-350.979, “Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession”

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precolligate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.

(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.

(4) Increasing the supply of minority health professionals.

| Retain; still relevant. |
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

H-360.981, “State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification”

Retain through incorporation into H-35.972, “Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation,” as follows:
1. It is the policy of our AMA that institutions offering advanced education in the healing arts and professions shall fully and accurately inform applicants and students of the educational programs and degrees offered by an institution and the limitations, if any, on the scope of practice under applicable state law for which the program prepares the student. 2. Our AMA disapproves of questions developed for the United States Medical Licensing Examination (USMLE) being used for purposes other than the assessment of physicians-in-training and physicians. 3. Our AMA, with the Council of Medical Specialty Societies, and members of the Federation, will continue to work with the National Board of Medical Examiners (NBME) to assure that accurate information continues to be presented in communications about the use of USMLE questions in the Doctor of Nursing Practice (DNP) examination. 4. Our AMA, through its representatives to the NBME, will continue to provide feedback as plans for the restructuring of the USMLE are developed and implemented. 5. Our AMA will request the NBME to emphasize in future publications that the DNP
certification examination is not for the purposes of licensure of nurses. 6. Our AMA will continue to monitor the use of questions developed for the USMLE and COMLEX by any group for purposes other than the assessment of physicians-in-training and physicians;

|AMA policy is that the integrity of the physician (MD/DO) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills and training of physicians (MDs/DOs). (Res. 212, I-08) |

|7. Our AMA policy is that the integrity of the physician (MD/DO) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills and training of physicians (MDs/DOs). (Res. 211, A-06 Appended: CME Rep. 10, A-10 Modified: CCB/CLRDP Rep. 2, A-14) |

**H-360.982, “Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside”**

Our AMA supports:
1. increased physician awareness of their role in solving the RN shortage at the bedside and the importance of physicians’ participation in efforts to relieve the shortage;
2. increased awareness of opportunities for physician leadership and participation in efforts to solve the RN shortage at the bedside;
3. physician efforts to identify those models and strategies that are most applicable to their communities and hospitals and, additionally, will produce the best results; and
4. national efforts to increase funding for bedside nursing education. (BOT Rep. 27, A-08) 

Sunset; still relevant, but superseded by D-360.998, “The Growing Nursing Shortage in the United States,” which reads: 
“Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields; 
(2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients; 
(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process; 
(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions; 
(5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care.”
### H-360.984, “Nursing Shortage”

| Our AMA supports proposals to increase basic nursing education opportunities, workforce incentives and similar efforts to increase the supply of registered nurses. (Res. 313, A-02 Reaffirmed: CME Rep. 2, A-12) | Sunset; superseded by D-360.998, “The Growing Nursing Shortage in the United States.” In particular, “Our AMA (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields....” |

### H-360.999, “Nursing Education”

| The AMA urges that a constructive attitude be assumed by the medical profession at all levels in an attempt to aid those closely concerned with nursing education, to increase the facilities for those training programs, and to aid in recruiting personnel into the training programs. (BOT Rep. D, A-59; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: CLRPD Rep. 1, I-98; Reaffirmed: CME Rep. 2, A-08) | Sunset; superseded by D-360.998, “The Growing Nursing Shortage in the United States.” In particular, “Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields; (2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients.... (4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions; (5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care.” |

### H-450.987, “Education of Physicians in Utilization and Quality Review Matters”

| The AMA (1) commends medical schools that provide instruction in quality assurance and utilization review; (2) advocates making available model curriculum information to medical schools wishing to undertake such instruction; (3) reaffirms its support for the provision in the ACGME Program | Sunset; superseded by H-450.994 (5), “Quality Assurance in Health Care,” which reads: “Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in clinical graduate training and |
Requirements which require that residents participate in patient care review activities; and (4) supports and encourages accredited sponsors which currently provide continuing medical education on the subject of quality assurance and utilization review or those which may be interested in developing educational activities for this purpose. (CME Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08)

<table>
<thead>
<tr>
<th><strong>HOD DIRECTIVES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number, Title, Policy</strong></td>
</tr>
</tbody>
</table>

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and partly to propose remedies to solve the problems identified in the AMA study.

6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities. (CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17)
**D-255.980, “Impact of Immigration Barriers on the Nation’s Health”**

<table>
<thead>
<tr>
<th>Item</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Our American Medical Association (AMA) recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.</td>
</tr>
<tr>
<td>2.</td>
<td>Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.</td>
</tr>
<tr>
<td>3.</td>
<td>Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.</td>
</tr>
<tr>
<td>4.</td>
<td>Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.</td>
</tr>
<tr>
<td>5.</td>
<td>Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.</td>
</tr>
<tr>
<td>6.</td>
<td>Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.</td>
</tr>
</tbody>
</table>

Retain in part; rescind Item 7, as having been fulfilled by Council on Medical Education Report 3-I-17, “Impact of Immigration Barriers on the Nation’s Health.”

**D-255.983, “Observerships for International Medical Graduates”**

<table>
<thead>
<tr>
<th>Item</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Our AMA will, through its relevant Sections, work with internal and external groups to develop guidelines for observership programs for International Medical Graduates (IMGs) who have received certification by the Educational Commission for Foreign Medical Graduates, including the following: (a) development of a set of educational objectives and a model curriculum outline; and (b) identification of educational/informational materials to address the objectives; and (c) creation of informational materials related to legal, organizational, and operational issues related to program implementation. (CME Rep. 12, A-08)</td>
</tr>
</tbody>
</table>

Sunset; this has been accomplished; see https://www.ama-assn.org/life-career/establish-observership-international-medical-graduates.
<table>
<thead>
<tr>
<th><strong>D-275.999, “Board Certification and Discrimination”</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Our AMA will collect information from members discriminated against solely because of lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification (Res. 314, I-98; Reaffirmed: CME Report 2, A-08)</td>
</tr>
<tr>
<td>Sunset; the action called for in this policy was addressed in Council on Medical Education Report 2-A-17, “Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 315-A-16),” which was adopted in lieu of Resolution 315-A-16, “Maintenance of Certification (MOC) and Licensure (MOL) vs. Board Certification, CME and Life-Long Commitment to Learning.” Resolve 2 of Resolution 315-A-16 asked that our AMA “develop an action plan to protect physicians when the Maintenance of Certification is punitively used as a requirement for licensure, credentialing, reimbursement, network participation or employment with a report back at Interim 2016.”</td>
</tr>
<tr>
<td>In response, the report noted: “Currently, MOC is meant to demonstrate proficiency within a chosen discipline, but is not required for state medical licensure. In addition, many hospitals have independently made the decision to require recertification for the granting of privileges, and various quality organizations and insurers use MOC to help identify commitment to professionalism and continuous performance improvement. These requirements are within their legal rights. However, some states are considering or have enacted legislation that prohibits the use of MOC as a criterion for privileging, employment, and reimbursement. Additional data will be needed to determine if an action plan should be developed to protect physicians when MOC is used as a requirement for licensure, credentialing, reimbursement, network participation or employment (Resolution 315-A-16, resolve 2). To date, the Council has not accumulated data on instances where this has occurred. However, when data become available, the Council will determine if these cases fit into a pattern and will advise the HOD on how to proceed.”</td>
</tr>
<tr>
<td>The principles behind this policy are also reflected in H-275.924 (15), “Maintenance of Certification”: “15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.”</td>
</tr>
</tbody>
</table>
### D-295.933, “Transparency In Medical Schools’ Utilization of Funds From Tuition and Fee Increases”

| Our AMA encourages the development of policies by Liaison Committee on Medical Education- and American Osteopathic Association-accredited medical schools that ensure information on the use of funds from tuition and fee increases is disclosed in a standardized format and in a timely manner to prospective and current medical students. (Sub. Res. 310, A-08) | Sunset. Schools are required to report to the LCME their actual tuition revenues, actual dollars accrued, and the percentage of total institutional revenues resulting from tuition. The complexity of medical school structure and expenditures as well as the diversity of medical school funding sources renders tracking of actual tuition dollars impossible. The LCME does monitor the percentage of total revenues from tuition dollars and expects that tuition revenues are less than 50 percent of total revenues. The LCME also monitors trends in tuition revenues, both actual dollars and the percentage of total revenues. The AOA Commission on Osteopathic College Accreditation monitors similar data among its accredited schools. |

### D-295.936, “Educational Implications of the Medical Home Model”

| Our AMA:  
1. encourages the integration of medical education into Patient-Centered Medical Home (PC-MH) demonstration projects;  
2. will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to review their accreditation standards so as not to impede education in and about the PC-MH model; and  
3. will advocate for funding from all sources for medical schools and residency training programs to provide medical education in the context of PC-MH models. (CME Rep. 4, A-08; Modified: Speakers Rep., I-15) | Sunset; superseded by D-200.979, “Barriers to Primary Care as a Medical School Choice,” which reads in part: “6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. 7. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 9. Our |
AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.”

In addition, related to D-295.936(2), LCME standards already allow for clinical educational scenarios that include assignment of medical students to patients’ homes and longitudinal experiences that emphasize continuity of patient care.

**D-295.938, “Increasing Medical School Class Sizes”**

| Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. (Res. 309, A-08) | Retain; still relevant. |

**D-295.939, “Independent Regulation of Physician Licensing Exams”**

| Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, “Voting Rights for AMA-MSS NBME Representatives;” (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). (CME Rep. 10, A-08) | Retain in part, with the deletion shown below, as H-295.893, “Voting Rights for AMA-MSS NBME Representatives,” has been accomplished and is being sunset through this report. Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, “Voting Rights for AMA-MSS NBME Representatives;” (2) continue to collaborate with the organizations that create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). (CME Rep. 10, A-08) |
### D-295.999, “Extending Impaired Physician Programs to Medical Students”

<table>
<thead>
<tr>
<th>Our AMA will inform students of the variety of options available for treatment of impairment, including medical school and state medical society programs. (CME Rep. 4, I-98; Reaffirmed: CME Report 2, A-08)</th>
<th>Sunset; superseded by H-295.863, “Impairment Prevention and Treatment in the Training Years,” which reads: “Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians.” (CCB/CLRDP Rep. 3, A-14)</th>
</tr>
</thead>
</table>

### D-300.983, “Financial Conflicts in CME”

<table>
<thead>
<tr>
<th>Our AMA will continue to monitor the implementation of the Accreditation Council for Continuing Medical Education 2004 Standards for Commercial Support and report to the House of Delegates any major evidence that these requirements are or are not effective in ensuring the independence of or adversely impact the availability of continuing medical education. (CME Rep. 13, A-08)</th>
<th>Sunset, no longer relevant. The ACCME Standards for Commercial Support have been in place since 2004, and have been adopted by many organizations and societies in the United States and elsewhere in the world. Monitoring is no longer necessary.</th>
</tr>
</thead>
</table>

### D-305.964, “Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion”

| Our AMA will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. (Res. 301, A-08) | Retain; still relevant. |
Our AMA will continue to advocate for additional funds from the federal government and other third party payers for GME programs that take place in non-hospital settings. (BOT Rep. 5, I-98; Reaffirmed: CME Report 2, A-08)

Sunset; superseded by D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” which reads in part:
“7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.”

Also reflected in H-305.929, “Proposed Revisions to AMA Policy on the Financing of Medical Education Programs,” which reads in part:
“H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.”

Also reflected in H-310.929, “Principles for Graduate Medical Education,” which reads in part:
“(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.”
**D-310.962, “Evaluation of Increasing Resident Review Committee Requirements”**

| **Our AMA will work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in studying residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. (Res. 315, A-08)** | **Retain; still relevant.** |

---

**D-360.994, “State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification”**

| **Our AMA, through its Council on Legislation, will work expeditiously to develop and circulate to all state medical and national medical specialty societies, model state legislation that would prohibit the National Board of Medical Examiners from using the past, present or future content of its United States Medical Licensing Examination Step 3 exam, and National Board of Osteopathic Medical Examiners from using the past, present or future content of its COMLEX Step 3 Exam in the certification processes for non-physician providers. (Res. 212, I-08)** | **Sunset.** |
The Council on Medical Education has monitored Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) during the last year. This annual report, mandated by American Medical Association (AMA) Policy D-275.954, “Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC),” provides an update on some of the changes that have occurred as a result of AMA efforts with the American Board of Medical Specialties (ABMS) to improve the MOC process.

In 2017, the ABMS Board adopted a new name, “Continuing Board Certification,” for its MOC Program (some ABMS member boards are still referring to the program as MOC). The ABMS and its 24 member boards also launched a major initiative to modernize continuing board certification. A planning committee established the “Continuing Board Certification: Vision for the Future” Commission to engage physicians, the public, and key stakeholders in a collaborative process.

This report highlights initiatives that are underway to improve MOC:
- Many ABMS member boards have taken steps to replace the MOC Part III examination with a more relevant, less onerous, and cost-efficient process for physicians. Some boards are looking at ways to innovate assessment of medical knowledge and are testing new models or have implemented alternatives to the traditional secure, high-stakes examination. The table at the end of this report summarizes the new models being implemented and/or piloted and board activities underway to improve the examination component (MOC Part III).
- The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) component (MOC Part IV). New activities are being implemented by the boards related to registries, systems-based practice, and practice audits.
- New studies published during the last year describe how new assessment models and IMP activities have resulted in improved quality and patient care and physician satisfaction.

Updates on the following MOC activities are also included in this report:
- AMA participation in meetings and conferences to improve the MOC process (pages 2-5)
- The ABMS Continuing Certification Directory (pages 5-6)
- Alternatives to the MOC Part III secure, high-stakes examination (pages 6-8)
- Improvement in medical practice (MOC Part IV) (pages 8-9)
- The ABMS Multi-Specialty Portfolio Program (pages 9-10)
- Emerging data and literature regarding the value of MOC (pages 10-13)
- Osteopathic Continuous Certification (pages 13-14)
- State legislation related to the use of MOC (pages 14-15)

The Council on Medical Education is committed to ensuring that continuing board certification supports physicians’ ongoing learning and practice improvement and can assure the public that physicians are providing high-quality patient care. The Council continues to work with the ABMS, ABMS member boards, American Osteopathic Association, state and specialty medical societies, and key stakeholders to identify and suggest improvements to continuing certification programs. During the next year, the Council will also be actively engaged in following the work of the ABMS Commission and the development of the Commission’s recommendations for the future continuing board certification process.
Subject: Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolutions 316-A-17 and 318-A-17)

Presented by: Lynne M. Kirk, MD, Chair

Referred to: Reference Committee C (Sherri S. Baker, MD, Chair)

Resolution 316-A-17, “Action Steps Regarding Maintenance of Certification,” Resolves 4 and 5, introduced by Florida, Pennsylvania, Georgia, California, New York, Arizona, Texas, American College of Radiation Oncology, and American Society of Intervventional Pain Physicians and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to:

4) join with state medical associations and specialty societies in directly lobbying state medical licensing boards, hospital associations, and health care insurers to adopt policy supporting the use of satisfactory demonstration of lifelong learning with high quality CME as specified by a physician’s specialty society for credentialing and bar these entities from using the ABMS sponsored MOC process using lifelong interval high stakes testing for credentialing; and

5) partner with state medical associations and specialty societies to undertake a study with the goal of establishing a program that will certify physicians as satisfying the requirements for continuation of their specialty certification by successful demonstration of lifelong learning utilizing high quality CME appropriate for that physician’s medical practice as determined by their specialty society with a target start date of 2020 or before, with report back biannually to the HOD and AMA members.

Resolution 318-A-17, “Oppose Direct to Consumer Advertising of the ABMS MOC Product,” introduced by Michigan and also referred by the HOD, asks the AMA to:

1) oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists; and

2) amend existing AMA Policy D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification” by addition as follows:

36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards’ websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes.
Policy D-275.954 (1), “Maintenance of Certification and Osteopathic Continuous Certification,” asks that the AMA continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the HOD regarding the MOC and OCC processes.

BACKGROUND

Reference Committee C heard mixed testimony on Resolution 316-A-17. There was overwhelming support for the first and second resolves, which are consistent with existing HOD policy that 1) affirms that lifelong learning is a fundamental obligation of the profession, and 2) recognizes that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) appropriate to that physician’s medical practice as determined by the relevant specialty society.

However, in accordance with existing policy, the AMA has already developed model state legislation intended to prohibit hospitals, health care insurers, and state boards of medicine and osteopathic medicine from requiring participation in MOC processes as a condition of credentialing, privileging, insurance panel participation, licensure, or licensure renewal. This model bill is on file with the AMA Advocacy Resource Center, which will assist any interested state medical associations in pursuing legislation that is consistent with AMA policy. The AMA has also focused on educating state medical associations about activity around the country, as well as on the risks and benefits of legislating the use of MOC. During the testimony, it was noted that enacted and defeated state legislation related to the use of MOC is complex and its potential impact on professional self-regulation is unknown. It was therefore recommended that the fourth and fifth resolves be referred for study with a report back to the HOD on the current status of such legislation.

The reference committee also heard mixed testimony related to Resolution 318-A-17. Although the AMA opposes direct-to-consumer marketing of drugs and devices, it was noted that this resolution focuses on a different kind of communication. It was also noted that the American Board of Medical Specialties (ABMS) is making a statement to inform the public about the certification status of physicians. There is no precedent in AMA policy that supports this issue, and the AMA has no purview over how the ABMS communicates information about its certification process. It was therefore recommended that this resolution be referred for further study.

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

The AMA Council on Medical Education and the AMA HOD have carried out extensive and sustained work in developing policy on MOC and OCC (Appendix A), including working with the ABMS and the American Osteopathic Association (AOA) to provide physician feedback to improve the MOC processes, informing our members about progress on MOC and OCC through annual reports to the House, and developing strategies to address the concerns about the MOC and OCC processes raised by physicians. The Council has prepared reports covering MOC and OCC for the past nine years. During the last year, Council members, AMA Trustees, and AMA staff have participated in the following meetings with the ABMS and its member boards:

• ABMS Board of Directors Meeting (2/27/2018 - 3/1/2018)
• American Board of Anesthesiology/ABMS Maintenance of Certification Research Summit (9/24-25/2017)
In 2017, the ABMS Board adopted a new name, “Continuing Board Certification,” for its MOC Program, but some member boards still refer to the program as MOC. The ABMS and its 24 member boards also launched a major initiative to modernize continuing board certification (visioninitiative.org). A planning committee was formed to establish the “Continuing Board Certification: Vision for the Future” Commission, which includes representatives from the ABMS, Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), Coalition for Physician Accountability, CMSS, and AMA Council on Medical Education, as well as public members. The Commission has been designed to engage physicians, the public, users of the credential, and other stakeholders in a collaborative process.

The planning committee identified the construct and membership of a 27-member Commission, and a member of the Council on Medical Education was selected to serve on the Commission. The planning committee also identified key questions for consideration by the Commission and will oversee a national opinion survey.

The Commission is in turn gathering information, holding hearings, addressing key questions, and making recommendations for the future continuing board certification process. During the course of its work, the Commission will generate several briefing documents for community consideration and feedback. The purposes of these documents are to present information about current and proposed practices, test concepts and ideas, and continue to engage the broader community in this process. The Commission will communicate with the broader community about the concepts and ideas and will engage in a series of discussions with stakeholders about different aspects of continuing board certification. This process is intended to facilitate the Commission’s building an achievable, sustainable model. In addition, portions of the Commission meetings will be open to guests; guests will be able to hear testimony, presentations, and discussions. The Commission will also meet in closed sessions.

On March 26, 2018, the AMA Council on Medical Education, ABMS, and ABMS member boards jointly convened a conference that included additional stakeholders (i.e., specialty societies, state medical societies, ACCME, American Hospital Association, Association for Hospital Medical Education, Association of American Medical Colleges, CMSS, and the Federation of State Medical Boards) to determine how continuing certification can meet the needs of diverse stakeholders and to develop recommendations that will be sent to the Commission for their consideration on behalf...
of the attendees. During the conference, several ABMS member boards shared the results of
surveys to obtain feedback from physicians regarding MOC and discussed some of their recently
implemented changes. In order to develop recommendations for the Commission, the conference
focused on the roles of the boards and specialty and medical societies to determine how
assessment, learning, and improvement in practice can be relevant, meaningful, and integrated with
the way physicians practice. A white paper summarizing the conference and final recommendations
is being considered by the Council at the suggestion of the attendees. The Commission is expected
to release a draft report for public comment in November 2018. A final report will be sent to the
ABMS in February 2019.

Report from the ABMS Committee on Continuing Certification

The Committee on Continuing Certification (3C) is charged with reviewing existing MOC
programs to ensure the ABMS member boards meet the 2015 Standards for the Program for MOC,
which evaluates the effectiveness of different approaches to MOC and identifies innovations to
share among the boards.

In 2017, 3C reviewed the Professionalism and Professional Standing (Part I) component of the
member boards’ Programs for MOC, seeking to understand the boards’ current processes for
assessing professionalism and responding to potential lapses. Additionally, the member boards
have been sharing information with 3C about pilot projects undertaken to enhance the experience
and value of their MOC programs for their diplomates.

Report from the ABMS meeting with medical societies to address physician concerns about MOC

On December 4, 2017, staff from the ABMS held a meeting with members of the CMSS, the
Specialty Society CEO Consortium (S2C2), state medical societies, and other stakeholders,
including a member of the Council on Medical Education, to discuss the MOC programs of its
member boards. The meeting focused on the critical issues and concerns physicians have raised
about MOC, what the ABMS member boards are doing to resolve these concerns, and how these
organizations can work together to create a future continuing board certification program that is
relevant and valuable to stakeholders, board certified physicians, and the patients they serve.

State medical and specialty societies voiced their members’ concerns about the complexity,
relevance to practice, and the time and indirect cost burden associated with MOC programs. They
also noted that physician frustration with MOC programs has led to legislative initiatives in many
states that would prevent hospitals from requiring physicians to recertify. The state medical society
leaders and their members expressed a desire to have ongoing input into the development of the
continuing certification programs, a commitment to action and transparency from the member
boards, and improved communication. In addition, they requested more consistency across the
boards’ continuing board certification programs in order to establish best practices across
specialties that also indicate the programs’ impact in improving patient care. All attendees agreed
on the need to jointly develop solutions to avoid a decline in the value of board certification and the
erosion of public trust in the ability of the profession to self-regulate.

The following “Statement of Shared Purpose” was agreed to by those present:

“ABMS certifying boards and national medical specialty societies will collaborate to resolve
differences in the process of on-going certification and to fulfill the principles of professional
self-regulation, achieving appropriate standardization, and assuring that on-going certification
is relevant to the practices of physicians without undue burden.
Furthermore, the boards and societies, and their organizations (ABMS and CMSS), will
undertake necessary changes in a timely manner, and will commit to ongoing communication
with state medical associations to solicit their input.”

On December 5, 2017, leaders from the CMSS membership, ABMS, ABMS member boards, and
additional guests met to discuss innovative approaches for continuous medical education. The
ABMS member boards discussed 170 innovations they are working on to address continuous
learning for physicians. Many of the innovations included input from various outside stakeholders
and focused on greater consistency amongst the member boards. The innovations included
alternatives to the high-stakes examinations with a focus on longitudinal learning for physicians in
their relevant practice areas. Many of the member boards outlined current (or planned) learning
modules that would be seamless for physicians, and they provided a gap analysis. There was also
discussion by some member boards about reducing the exam fees and the need for the member
boards to be more “customer friendly” when dealing with their diplomates. The member boards are
interested in bidirectional communication going forward.

Update on new innovative CME models

The AMA and the ACCME have been collaborating on a strategy to more closely align the two
organizations’ requirements, simplify the system, and eliminate any barriers that would constrain
innovation in educational development and the delivery of CME.¹⁰ Both organizations want to
ensure the education community has the permission to provide more CME options to physicians
that integrate new technology and are adaptable to their learning style, accessible, and relevant. A
proposal that was developed with various groups (including staff, volunteers, and the leadership
from accredited organizations and state medical societies) about how to simplify the system to
better support the evolution of CME was adopted by the AMA and ACCME and went into effect in
September 2017.

The ABMS and its member boards are also collaborating with academic medical centers, specialty
societies, and other continuing professional development/continuing medical education
(CPD/CME) stakeholders to help board certified physicians find quality certified CME activities
linked to components of the ABMS Program for MOC.

ABMS Continuing Certification Directory

The ABMS “Continuing Certification Directory,” formerly called the “MOC Directory”
(continuingcertification.org/) continues to offer physicians access to a comprehensive, centralized,
web-based repository of CME activities that have been approved for MOC credit by ABMS
member boards. During the past two years, the directory has increased its inventory and now
indexes 600-plus activities from more than 60 CME providers to help diplomates from across the
specialties meet MOC requirements for Lifelong Learning and Self-Assessment (Part II) and
Improvement in Medical Practice (Part IV).

The following types of activities are currently included in the directory: internet enduring activities,
journal CME, internet point of care, live activities, and performance improvement CME. All CME
activities are qualified to award credit(s) from one or more of the CME credit systems: AMA PRA
Category 1 Credit™, AAFP Prescribed Credit, ACOG Cognates, and AOA Category 1-A.

The directory includes a wide variety of activities addressing emerging issues such as physician
well-being and safe opioid prescribing initiatives as well as a full suite of AMA STEPS Forward™
Practice Improvement Strategies. STEPS Forward offers more than 40 online modules, plus
resources, case studies, and other content around patient care, work flow process, leading change, professional well-being, technology, and finance. The ABMS has invited the CPD/CME communities to submit for inclusion in the directory any certified CME activities that support the development of high-functioning physicians. For example, the most recent call for activities (abms.org/news-events/abms-call-for-physician-well-being-cme-activities/) focuses on improving physician well-being.

The ACCME continues to collaborate with the American Board of Internal Medicine (ABIM), American Board of Anesthesiology (ABA), and American Board of Pediatrics (ABP); allows accredited CME providers to identify CME activities that also meet the MOC requirements for each of the member boards (ABIM, ABA, and ABP); and facilitates reporting of learner data from the accredited provider to the relevant member board (accme.org/news-publications/news/accreditation-council-cme-american-board-anesthesiology-and-american-board).

The collaborations are designed to expand the number and diversity of accredited CME activities that meet the member boards’ MOC Part II requirements. This simplifies a physician’s search for approved activities (cmefinder.org/). CME providers are using the ACCME Program and Activity Reporting System (PARS) to attest that their activities comply with board requirements. The ACCME maintains a list of accredited and certified CME activities registered for ABIM MOC, ABA MOC, and ABP MOC. The ABIM currently has more than 6,200 activities that have been certified for CME credit and registered for MOC points. Many of these activities are available across specialties, while some are specialty specific. The AMA transmits JAMA Network data to the ACCME for ABIM and is considering expansion to additional boards in the future.

Elimination of the secure, high-stakes examination for assessing knowledge and cognitive skills in MOC

Twenty-one ABMS member boards (87.5%) have moved away from the secure, high-stakes exam, and more than two thirds of the boards (71%) have launched, or will soon be launching, assessment pilots that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that promote learning and are less stressful (Table). A number of them are combining the longitudinal assessment approach with CertLink™, a technology platform developed by the ABMS to support its boards in delivering more frequent, practice-relevant, and user-friendly competence assessments to physicians (abms.org/initiatives/certlink-platform-and-pilot-programs/).

The platform provides the technology to enable the boards to create assessments focused on practice-relevant content; offers convenient access on desktop, tablet, or smartphone (depending on the board’s program); provides immediate, focused feedback and guidance to resources for further study; and provides a personal dashboard that displays areas of strength and weakness. The member boards that are developing CertLink™ pilot programs include the American Board of Colon and Rectal Surgery (ABCRS), American Board of Dermatology (ABD), American Board of Medical Genetics and Genomics (ABMGG), American Board of Nuclear Medicine (ABNM), American Board of Otolaryngology (ABOto), American Board of Pathology (ABPath), and American Board of Physical Medicine and Rehabilitation (ABPMR).

Other ABMS member boards that have been piloting new innovative assessment approaches have received positive feedback on their pilots. For example, the ABA surveyed its physicians in December 2016 to collect their feedback on year one of the redesigned Maintenance of Certification in Anesthesiology Program® (known as MOCA 2.0®). Nearly 75 percent of the physicians who responded reported that the MOCA Minute® pilot served them well as an assessment tool. Additionally, nearly 62 percent of survey respondents rated the experience better or much better than their experience with the traditional MOCA exam. Furthermore, physicians who participated in the 2014 and 2015 MOCA Minute pilot outperformed non-participants on the
MOCA Exam, according to a study published in the November 2016 issue of *Anesthesiology*.\(^1\) In January 2017, the ABA expanded its longitudinal assessment program to include diplomates maintaining subspecialty certificates.

In January 2017, the ABP launched a pilot of its proposed longitudinal assessment approach called Maintenance of Certification Assessment for Pediatrics (MOCA-Peds) ([abp.org/mocapeds](http://abp.org/mocapeds)). Nearly all 5,000 diplomates—approximately 98 percent of those eligible—enrolled in the 2017 MOCA-Peds pilot. At the end of each quarter, the ABP surveyed pilot participants about their experiences. Highlights from the first two surveys showed that 92 percent of participants had a satisfactory experience with the information technology platform, and nearly 80 percent agreed or strongly agreed that the MOCA-Peds questions were relevant to general pediatrics.\(^1\) Based on this feedback, the ABP plans to replace the 10-year secure exam with MOCA-Peds beginning in 2019.

In 2018, the ABIM began offering a new two-year assessment option to provide physicians more choice, relevance, and convenience in meeting the assessment requirement of its MOC program. These “Knowledge Check-Ins” will allow diplomates to take shorter assessments in a location of their choice. The ABIM will first pilot the Knowledge Check-In for physicians certified in internal medicine or nephrology. The shorter assessments will become available to other specialties in 2019 and 2020 as an additional option along with the traditional 10-year MOC exam.

Several member boards are considering or have integrated journal article-based core questions into their assessments. The American Board of Obstetrics and Gynecology (ABOG) launched its MOC Pilot Program ([abog.org/new/abog_mocimp.aspx](http://abog.org/new/abog_mocimp.aspx)) in 2016; more than 2,000 physicians opted to participate. In a survey of pilot participants conducted in 2017, 93 percent of the 1,268 respondents affirmed that the journal article assignments—a core element of the pilot—are beneficial to their clinical practice. Additionally, 87 percent of respondents agreed that if the ABOG fully adopts the pilot, it will make MOC more valuable to clinical practice, and 89 percent agreed that it will make MOC more relevant to clinical practice.\(^1\) The ABOG studied the pilot results through 2017 and will decide whether to permanently adopt the changes to its MOC program in 2018.

Preliminary analysis from the American Board of Ophthalmology’s (ABO) new Quarterly Questions™ program ([diplomatedigest.com/single-post/2018/02/06/Article-Based-Learning-and-Assessment-in-Quarterly-Questions](http://diplomatedigest.com/single-post/2018/02/06/Article-Based-Learning-and-Assessment-in-Quarterly-Questions)), launched in 2017, has been extremely favorable, earning the support of ABO diplomates as an approach to learning and assessment. Nearly 20 percent of ABO’s active diplomate population participated in the program’s optional pilot year, with 94 percent reporting that the article-based questions were useful for learning new, relevant information. Eighty-five percent of participants said the information they learned while completing the activity would help them provide better care to their patients in the future, and 99 percent said they would recommend the program to a colleague.

Other member board efforts include more diplomate input into exam blueprints; modularization of exam content that allows for tailoring of assessments to reflect physicians’ actual areas of practice; access during the exam to resources similar to those used at the point of care; remote proctoring to permit diplomates to be assessed at home or in the office; and performance feedback mechanisms. All boards will also provide multiple opportunities for physicians to retake the exam. These program enhancements will significantly reduce the cost diplomates incur to participate in MOC by reducing the need to take time off or travel to a testing center for the assessment; ensure that the assessment is practice relevant; emphasize the role of assessment for learning; assure opportunities for remediation of knowledge gaps; and reduce the stress associated with a high-stakes test environment.
Progress with improving MOC Part IV, Improvement in Medical Practice

The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements, including those offered at the physician’s institution and/or individual practices, in order to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. In addition to improving alignment between national value-based reporting requirements and continuing certification programs, the boards are implementing a number of activities related to registries, systems-based practice, and practice audits.

Registries

The ABMS member boards are increasingly incorporating the use of patient registries into their continuing certification process. Registries target quality concerns and provide physicians with meaningful, actionable information that helps align their MOC activities with federal and state quality incentive programs. While many member boards have been providing physicians the opportunity to earn MOC credit for participating in externally developed patient registries, some boards are designing performance improvement initiatives supported by registry data. Many of the member boards also recognize participation in registries developed by their professional societies as satisfying their IMP requirements.

- In 2017, the ABO began piloting a program that enables ophthalmologists to create customized quality improvement (QI) projects using the data supplied through the American Academy of Ophthalmology’s IRIS® Registry. After numerous improvement projects were successfully completed, ABO transitioned the pilot into a permanent program in October 2017. Ophthalmologists can use the monthly reports to identify areas for improvement, set specific goals for each measure, outline the steps (changes in care delivery processes) to achieve these goals, and evaluate their success by analyzing subsequent monthly performance reports. Ophthalmologists receive MOC credit for approved, completed projects.

- The ABOto has partnered with the American Academy of Otolaryngology-Head and Neck Surgery for the past two years to develop a qualified clinical data registry, Reg-ent. This registry is able to extract data from an otolaryngologist’s electronic health records (EHRs) for multiple purposes, including reporting quality measures for Merit-based Incentive Payment System (MIPS) as payment shifts to performance under the Quality Payment Program. The ABOto will be able to extract data from Reg-ent to provide feedback to board certified otolaryngologists and document improvement, thereby meeting MOC requirements without requiring data entry by the physicians.

- More than 3,000 physicians are using the American Board of Family Medicine (ABFM) PRIME Registry, which extracts patient data from the practice EHR and converts it into actionable measures that are presented in an easy to use dashboard. The PRIME Registry is a qualified clinical data registry that is approved to propose measures to the Centers for Medicare & Medicaid Services (CMS). The ABFM’s PRIME Registry offers tools that simplify and automate reporting for MIPS and CMS’s Comprehensive Primary Care Plus or CPC+, and enables physicians to use their measures data to create and implement a QI plan in their practice to simplify continuous certification and align it with MIPS reporting requirements. The ABFM is also developing a new tool, the Population Health & Assessment Engine, to integrate social determinants of health data with clinical data in the registry to help physicians understand the impact of social determinants on individual patients and the populations they serve and to improve intervention and care.
Interoperability between clinical data registries and EHRs continues to be a priority for specialty society registry hosts. CMSS published the Registry Primer to serve as background and a resource guide on clinical registry development and implementation (https://cmss.org/732-2/). CMSS member societies are also exploring a Clinical Data Registry Collaborative, which is planning a pilot project to identify and match patient-centric data elements from two or more data registries in their current hosting environment. CMSS plans to engage with the National Quality Registry Network and the National Quality Forum, which are exploring similar interoperability challenges.

Systems-based practice

The ABMS member boards are aligning MOC activities with other organizations’ QI efforts to reduce redundancy and physician burden while promoting meaningful participation. Twenty-one of the boards encourage participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™ (described below). Many boards encourage involvement in the development and implementation of safety systems or the investigation and resolution of organizational quality and safety problems. For physicians serving in research or executive roles, some boards have begun to give IMP credit for having manuscripts published, writing peer-reviewed reports, giving presentations, and serving in institutional roles that focus on QI (provided that an explicit Plan-Do-Study-Act [PDSA] process is used). Physicians who participate in QI projects resulting from morbidity and mortality conferences and laboratory accreditation processes resulting in the identification and resolution of quality and safety issues can also receive IMP credit from some boards.

Practice Audits

Several ABMS member boards have developed online practice assessment protocols that allow physicians to assess patient care using evidence-based quality indicators. Other initiatives include:

- Free tools to complete an IMP project, including a simplified and flexible template to document small improvements, educational videos, infographics, and enhanced web pages.
- Partnering with specialty societies to design quality and performance improvement activities for diplomates with a population-based clinical focus.
- Successful integration of patient experience and peer review into several of the boards’ IMP requirements; one board has aggressively addressed the issue of cost and unnecessary procedures with an audit and feedback program.
- Integration of simulation options.
- A process for individual physicians to develop their own improvement exercises that address an issue important to them, using data from their own practices, built around the basic PDSA process.

ABMS Multi-Specialty Portfolio Program

The ABMS Multi-Specialty Portfolio Program (Portfolio Program™) offers health care organizations a way to support physician involvement in their institution’s quality and performance improvement initiatives by offering credit for the IMP component of the ABMS Program for MOC (mocportfolioprogram.org). Originally designed as a service for large hospital institutions, the Portfolio Program is extending its reach to physicians whose practices are not primarily in institutions. This includes non-hospital organizations such as academic medical centers, integrated delivery systems, interstate collaboratives, specialty societies, and state medical societies. Recent additions among the 93 current sponsors include the American College of Cardiology, American Hospital Association, and American College of Obstetricians and Gynecologists.
More than 2,600 types of QI projects have been approved by the Portfolio Program, focusing on such areas as advanced care planning, cancer screening, cardiovascular disease prevention, depression, immunizations, obesity, patient-physician communication, transitions of care, and patient-safety related topics including sepsis and central line infection reduction. Many of these projects have had a profound impact on patient care and outcomes. For example, during the past two years, Portfolio Program initiatives at the Children’s Hospital of Philadelphia have been responsible for inpatient hospital days for oncology patients with fever and neutropenia decreasing by more than 35 percent, preventable readmissions for neurology patients decreasing by approximately 80 percent, and rates of urinary catheterization for febrile infants decreasing by 65 percent. Additionally, rates of pneumococcal immunization among patients with chronic kidney disease have increased by 79 percent, and the application of evidence-based practices to evaluate and manage children with attention deficit disorder and hyperactivity has increased by 50 percent. There have been nearly 19,700 instances of physicians receiving MOC IMP credit through participation in the program. Twenty ABMS member boards participate in the program.

Update on the emerging data and literature regarding the value of MOC

The Council on Medical Education has continued to review published literature and emerging data as part of its ongoing efforts to critically review MOC and OCC issues. Although there is still frustration with the MOC process and its cost,14 many improvements have been made to the MOC Program, such as making the process more efficient, convenient, and cost-effective, and less burdensome. In addition, important peer-reviewed studies published during the last year demonstrate the benefits of participating in a continuous certification program. These studies are summarized below.

Many of the ABMS member boards have been enhancing the MOC Part III examinations to ensure the exam is practice-relevant. A study by Gray et al. analyzed whether the ABIM MOC exams from 2010-2013 reflected practice conditions during either office visits or hospital stays for each of 186 condition categories within internal medicine. The study showed that the majority of exam questions generally reflected what occurs in practice, with 69 percent of the questions on these exams harmonizing with conditions in practice.15 A study by Lipner et al., involving 825 physicians initially certified by the ABIM or who took the ABIM MOC exam in 2012 to 2015, compared the results of a closed book exam to an open book exam that allowed the use of electronic resources typically used at the point of care. The study showed that inclusion of an electronic resource with time constraints did not adversely affect test performance and did not change the specific skill or factor targeted by the exam.16

One study looked at the benefits derived from taking the MOC Part III examination. More than 2,500 emergency physicians who took the American Board of Emergency Medicine (ABEM) ConCert high-stakes examination in 2015 participated in a voluntary post-examination survey in 2015. When asked about the benefits of preparing for the exam and maintaining ABEM certification, the majority of emergency physicians (more than 90 percent) reported they either gained medical knowledge or reinforced knowledge they already had, making them better clinicians. Most of them also found career benefits to remaining ABEM certified, including greater employment choices, higher financial compensation, and higher esteem from other physicians.17

A number of recently published studies evaluate the effectiveness and value of IMP activities (MOC Part IV).

- A study conducted by the University of Michigan Health System Adolescent Health Initiative evaluated whether a MOC Part IV project could improve the delivery of confidential care to
minor adolescent patients seen in outpatient primary care practices. This study showed that this Part IV project was an effective way to change physician practice and improve the delivery of confidential care to minor adolescents seen for wellness visits. The study also showed that another major benefit was that it served as the primary mechanism to get physicians in non-adolescent specialties engaged in improving care for adolescents. In addition, participation broadly increased participating primary care physicians’ knowledge of best practices in adolescent care, which may lead to wider improvements for adolescents in the practice as a whole.18

• A study of pediatric gastroenterologists who participated in a MOC Part IV activity showed significant improvements in clinical care documentation and processes as well as improvements in patient outcomes for various endoscopic procedures. In addition, parents had a much greater understanding of the informed consent process. An analysis of data taken from web-based MOC QI modules also showed significant practice variation across several processes and demonstrated how the web-based MOC activities improved them.19

• In a study that examined whether organization-developed MOC performance improvement modules (PIMs), such as the PIMs created by the ABP, improve the quality of pediatric care, the PIMs were linked to better care for children. Pediatricians improved care for attention-deficit/hyperactivity disorder, asthma, and influenza. Hand hygiene also improved.20

• A study of hypertension Performance in Practice Modules completed by family physicians from July 2006 through 2013 showed that these physicians significantly improved the quality of care for patients with hypertension, including improving blood pressure control and diet and exercise counseling, after completing the activity.21

• A study undertaken at Nationwide Children’s Hospital evaluated the effectiveness of integrating QI training within the institution by developing a course called “Quality Improvement Essentials” in 2012. The results of surveys were positive, indicating increased and maintained QI competency among staff. Approximately 40 percent of the physicians who participated in the course converted their course project to receive MOC Part IV credit.22

• A study by Jennings, et al., evaluated a QI project in a community emergency department (ED) aimed at decreasing the use of head computed tomography (CT) scans in children. The study showed that pediatricians who participated in the MOC activity reduced the use of unnecessary head CT scans for children with head injuries in the ED. In addition, coaching and mentoring from a regional hospital participating in the MOC Portfolio Program (Seattle Children’s Hospital) had a significant effect on the successful QI effort at the community setting.23

• Shaw et al. described how pediatric physicians’ increased participation in MOC Part IV QI activities at the Children’s Hospital of Philadelphia is improving patient care (e.g., asthma management, patient flow, and cardiac arrest outcomes).24

Recently published articles describe improvements made to the continuing certification process.

• One article describes how the American Board of Allergy and Immunology’s (ABAI) Part III continuous assessment program will replace the ABAI’s 10-year high-stakes examination beginning in 2018. This process will be an open-book and web-based program that will focus on adult learning theory methods to reduce the cost and burden on diplomates.25
Two articles discuss how improvements being made to the MOC process make continuing certification more meaningful and acceptable to physicians. The ABIM and ABP have worked closely with their specialty societies to increase the number of CME programs that count for MOC. In addition, the ABIM and ABP have tested and evaluated new assessment models to replace the 10-year high-stakes examinations.26, 27

An article by Juul et al. highlights the development of geriatric psychiatry subspecialty certification. The article focuses on how the American Board of Psychiatry and Neurology (ABPN) is attempting to meet the need for more geriatric psychiatrists by strategically developing a flexible approach to MOC that includes options for taking combined examinations which cover their diplomates’ specialty and/or subspecialty. Other ABPN MOC requirements are the same as those for recertification in general psychiatry only or in a single subspecialty.28

An article by Carlos et al. provides an overview of how the American Thoracic Society developed a core curriculum focusing on adult pulmonary, critical care, and sleep medicine and pediatric pulmonary medicine that can be integrated into the MOC programs offered by the ABIM and ABP. The guiding principles outlined in this article may aid other societies that are considering launching similar initiatives to meet the needs of their members.29

An article by McMillan et al. addresses the importance of focusing on behavioral and mental health in pediatric resident training and the efforts being made by the ACGME and ABP to improve this area of need. This article also identifies how MOC will be used to try to improve learning.30

Three articles describe quality measurement that is being used in clinical care improvement, regulation, accreditation, public reporting, surveillance, and MOC. A 2015 quality metrics (QUALMET) survey assessed the commonalities and variability of selected quality and productivity indicators, including MOC participation, currently used by 112 U.S. academic radiology departments. MOC participation was found to be varied and a requirement of employment for nearly half of the survey respondents. The study suggests that MOC is currently the best metric to evaluate whether a radiologist has up-to-date knowledge and is familiar with quality and safety practices.31 A policy statement published by the American Academy of Pediatrics recommended that national policymakers “harmonize and align measures used in national/state reporting programs, including payment programs, such as state Medicaid and private payers, accreditation bodies, regulatory agencies, and MOC programs to reduce reporting burden on physicians.”32 An article by Price and Lang presents a QI model for the clinical practice of allergy and immunology that can be used by physicians to develop and implement practice-based QI activities that improve processes and outcomes of care for patients.33

Recent articles also evaluate self-regulation, professionalism, and perceptions about MOC. A review of retrospective cohort studies between MOC and clinical processes or outcomes, published from 2007 to 2016, shows that although methodological challenges remain, a rapidly growing body of literature provides evidence that MOC is associated with better care or has been an incentive for physicians to collaborate in systematically improving patient care and outcomes.34 A review article summarizes the challenges of teaching and assessing professionalism in radiology, how professionalism is part of MOC and the American Board of Radiology’s competency assessment, and how a greater understanding of professionalism as part of competency assessment is needed.35 A study conducted by the Seattle Children’s Hospital showed that, of 123 physicians who participated in a MOC project and completed a survey, 97 percent of the survey respondents view...
Part IV favorably. Participation was associated with modest improvements in perceptions of QI engagement and attitude, application of QI methods, and patient care. More than 60 sessions at the ABMS annual QI Forum held during the 2017 ABMS Conference focused on continuing certification, initial certification, health policy research, patient safety, and improvement in medical practice. Posters presented by Portfolio Program sponsors and other health care researchers underscored best practices and research in continuing certification and QI activities. One example highlighted a program at the University of Michigan Health System in which more than 40 QI projects are available for physician participation, including improving the rate of foot exams for adult diabetic patients, reducing the number of non-medically indicated planned deliveries, and improving the clinical management of overweight and obese pediatric patients.

Stakeholders from the fields of medical education and assessment also met to develop a collaborative research agenda and strategy to study learning and assessment throughout a physician’s career during the 2017 ABA/ABMS Research Summit entitled, “Improving Health and Healthcare Systems: Defining a Research Agenda for Learning and Assessment across the Continuum of a Physician’s Career”.

The Council on Medical Education is committed to monitoring emerging data and the literature to identify improvements to the MOC program, especially those that improve physician satisfaction with MOC as well as those that enable physicians to keep pace with advances in clinical practice, technology, and assessment.

OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC): AN UPDATE

The American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. Today, 18 AOA-BOS specialty certifying boards offer osteopathic physicians the option to earn board certification in a number of specialties and subspecialties. As of December 2016, over 29,000 osteopathic physicians held active board certification through the AOA (with some of these physicians holding multiple certifications). OCC was implemented on January 1, 2013, by all 18 specialty certifying member boards of the AOA-BOS. All osteopathic physicians who hold a time-limited certificate are required to participate in the following five components of the OCC process in order to maintain osteopathic board certification:

- Component 1 - Active Licensure: physicians who are board certified by the AOA must hold a valid, active license to practice medicine in one of the 50 states, District of Columbia, or U.S. territories, and adhere to the AOA’s Code of Ethics.
- Component 2 - Life Long Learning/Continuing Medical Education (CME): requires that all recertifying diplomates fulfill a minimum number of hours of CME credit during each three-year CME cycle (15 certifying boards require 120 hours; three certifying boards require 150 hours). A minimum of 50 credit hours of this requirement must be in the specialty area of certification. Self-assessment activities are also designated by each of the 18 specialty certification boards. For osteopathic physicians who hold subspecialty certification(s), a percentage of their specialty credit hours must be in their subspecialty certification area.
- Component 3 - Cognitive Assessment: requires provision of one (or more) psychometrically valid and proctored examinations that assess a physician’s specialty medical knowledge as well as core competencies in the provision of health care.

- Component 4 - Practice Performance Assessment and Improvement: requires that physicians engage in continuous quality improvement through comparison of personal practice performance measured against national standards for their respective medical specialty.

- Component 5 - Continuous AOA Membership.

Specific requirements for each specialty are available at: osteopathic.org/inside-aoa/development/aoa-board-certification/occ-requirements/Pages/default.aspx.

Although osteopathic physicians who hold non-time-limited (non-expiring) certificates are not required to participate in OCC, there are requirements to maintain active certification status: they must continue to meet licensure, membership, and CME requirements (120-150 credits every three-year CME cycle, 30 of which are in AOA CME Category 1A).

In April 2016, the AOA empaneled a Certifying Board Services Task Force charged with the following tasks:

1. Improve customer experience through user-friendly processes.
2. Continuously increase quality and enhance standards of high-stakes examinations.
3. Simplify and align the OCC process across all specialties.
4. Serve as a focus group on technological enhancements.

In July 2016, the AOA House of Delegates approved a resolution calling for the AOA to study and evaluate all components of OCC. The Task Force reported its findings and recommendations regarding the five OCC components to the BOS at its annual meeting on November 6, 2016. The Task Force’s recommendations focus on making the OCC process less onerous and apply current and new evaluation processes that take advantage of the latest concepts in certification and supporting technology. The BOS drafted resolutions based on the Task Force’s recommendations and submitted these to the AOA Board of Trustees for approval at its February 2017 meeting. The resolutions were approved by the AOA Board of Trustees and the individual boards are now working on implementation plans for the updated OCC components.

STATE LEGISLATION RELATED TO THE USE OF MOC

MOC is intended to be a career-long process of learning, assessment, and performance improvement that is meant to demonstrate physicians’ proficiency within a chosen discipline, but is separate from and not required for state medical licensure. Many hospitals have independently made the decision to require recertification for the granting of privileges, and various quality organizations and insurers use MOC to help identify commitment to professionalism and continuous performance improvement. These requirements are within their legal rights. However, AMA policy discourages such mandates. The AMA has adopted the following related policies:

- Policy H-275.924, “Maintenance of Certification,” (15) states, “The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.”

- Policy D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification,” (34) states that the AMA, “through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state
legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.”

Some states are proposing or have enacted legislation that prohibits the use of MOC as a criterion for licensure, privileging, employment, reimbursement, and/or insurance panel participation. Nine states (Arizona, Georgia, Kentucky, Maryland, Maine, Missouri, Oklahoma, Tennessee, and Texas) have enacted laws addressing MOC requirements. With the exception of Texas, where the enacted legislation has implications for hospitals’ and health plans’ use of MOC, the laws passed to date prohibit the use of MOC for initial and renewal licensure decisions. At the time of filing, 18 state legislatures (Alaska, Florida, Iowa, Indiana, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Utah, Washington, and Wisconsin) were actively considering MOC-related legislation.

The AMA Council on Legislation has developed, and the AMA Board of Trustees has approved, model state legislation intended to prohibit state boards of medicine and osteopathic medicine from requiring physicians to maintain certification for licensure or license renewal; prohibit hospitals from denying staff privileges or admitting privileges to a physician solely based on the physician’s lack of participation in MOC or OCC; and prohibit insurers from denying reimbursement to a physician, or preventing a physician from participating in the insurer’s network, based solely on the physician’s lack of participation in MOC or OCC. The model bill is on file with the AMA Advocacy Resource Center, which will assist any interested state medical association in pursuing such legislation or any other legislation consistent with AMA policy.

DIRECT-TO-CONSUMER ADVERTISING OF THE ABMS MOC PRODUCT

Society relies on members of the medical profession to establish standards for entering the profession and to assure that they are maintaining competence throughout their careers. Patients expect that their physician’s certification reflects ongoing education and practice improvement. Board certification makes a public statement about a physician’s capabilities to provide quality care in his or her chosen specialty. Patients, families, and others have a right to know a physician’s certification status, and they should also be able to access this information through multiple channels and in formats that are easily understood.

Although the AMA opposes direct-to-consumer marketing of drugs and devices, Resolution 318-A-17 focuses on a different aspect of marketing. Health professionals, both physicians and non-physicians alike, are generally allowed to advertise to the public their training, education, experience, and expertise. Twenty states have enacted legislation prohibiting deceptive or misleading advertising, communication, or other deceptive or misleading conduct concerning health professionals’ skills, education, training, professional competence, or licensure.

Some physicians may advertise that they are board certified or board eligible. The AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of ABMS- or AOA-BOS-board certified physicians in any medical specialty, or takes advantage of the prestige of any medical specialty for purposes contrary to the public good and safety (H-275.926 (1), “Medical Specialty Board Certification Standards”). Similarly, the AMA’s “Truth in Advertising” campaign highlights the need to improve transparency, clarity, and reliability for the patient and public. Through this campaign, the AMA developed materials including a model bill, the “Health Care Professional Transparency Act,” which includes a drafting note with sample language for use by state and specialty societies that wish to pursue legislation governing advertising about physician certification status (ama-assn.org/truth-advertising). The
campaign provides medical societies with tools and resources to develop and advocate for legislation to help ensure that patients are promptly and clearly informed of the training and qualifications of their health care practitioner.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education is committed to ensuring that MOC and OCC support physicians’ ongoing learning and practice improvement and serve to assure the public that physicians are providing high-quality patient care in their practice settings. The AMA will continue to advocate for a certification process that is evidence-based and relevant to clinical practice as well as cost-effective and inclusive to reduce duplication of work. During the last year, the Council has continued to monitor the development of MOC and OCC and work with the ABMS, ABMS member boards, AOA, and the state and specialty medical societies to identify and suggest improvements to the MOC and OCC programs. Since the AMA will continue to work with these organizations and key stakeholders and a council member will be closely involved in the ABMS Commission and in the development of the Commission’s recommendations for the future continuing board certification process, a study with the goal of establishing a program that will certify physicians is not warranted at this time.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolutions 316-A-17 and 318-A-17 and the remainder of the report be filed.

1. That our American Medical Association (AMA) continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so. (Directive to Take Action)

2. That our AMA, through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission. (Directive to Take Action)

Fiscal Note: $2,500
TABLE. IMPROVEMENTS TO THE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) PART III, SECURE, HIGH-STAKES EXAMINATION*

<table>
<thead>
<tr>
<th>American Board of:</th>
<th>Current Examination Format</th>
<th>New Models/Innovations</th>
</tr>
</thead>
</table>
| Allergy and Immunology (ABAI) abai.org | Computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years. | In 2018, ABAI-Continuous Assessment Pilot Program will be implemented in place of current exam:  
- A 10-year program with two five-year cycles.  
- Diplomates take exam where and when it is convenient.  
- Open-book exam with a total of approximately 80 questions per year.  
- Mostly article-based with some core questions during each six-month cycle. Diplomates are required to answer three questions for each of ten journal articles in each cycle. The articles will be posted in January and July and remain open for six months. Articles can be printed or downloaded for review.  
- Questions can be answered for each article independently. Diplomate feedback on each question will be required.  
- Opportunity to drop the two lowest six-month cycle scores during each five-year period to allow for unexpected life events.  
- Ability to complete questions on PC, laptop, MAC, tablet, and smart phone formats by using the new diplomate dashboard via the existing ABAI Web Portal page. |
| Anesthesiology (ABA) theaba.org | 1) MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment and provide more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise.  
2) Piloting MOCA Minute™—a longitudinal assessment tool that requires diplomates to answer 30 questions per calendar quarter, or 120 per year, in lieu of taking a 10-year exam.  
*All diplomates with time-limited certification that expired on or before Dec. 31, 2015 and diplomates whose subspecialty certificates Analysis of the pilot data is underway to determine whether participants accessed the links to additional resources, learned the material, and improved performance in the content knowledge areas represented in the MOCA Minute Pilot. |
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Description</th>
<th>Updates</th>
</tr>
</thead>
</table>
| Colon and Rectal Surgery (ABCRS)¹ **abcrs.org** | Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years.                                                                 | • Exploring ways to modify the exam experience to provide a more consistent evaluation process and to replace the exam as it presently is administered. The ABCRS is developing a CertLink™-based longitudinal assessment pilot to evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.  
  • The first diplomates enrolled are those sitting for the ABCRS certifying exam in September 2017. These diplomates start CertLink™ MOC in the Spring of 2018. Other diplomates will be able to enroll shortly thereafter. |
| Dermatology (ABD)¹ **abderm.org**              | • Computer-based secure modular exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years.  
  • Test preparation material available six months before the exam at no cost. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams.  
  • Examinees are required to take the general dermatology module, consisting of 100 clinical images to assess diagnostic skills, and can then choose among 50-item subspecialty modules. | • The ABD successfully completed trials employing remote proctoring technology to monitor exam administration in the diplomates’ homes or offices.  
  • The ABD is developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam. |
| Emergency Medicine (ABEM) **abem.org**         | ABEM’s ConCert™, computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.                                                            | The ABEM is monitoring recent efforts within the ABMS board community that have focused on pilots that assess knowledge, judgment, and skills using longitudinal assessments rather than an every-10-year exam. The alternative assessment method would have to show that its learning and assessment advantage is better than the current ABEM exam. |
| Family Medicine (ABFM) **theabfm.org**         | • Computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years.  
  • Improving relevance of recertification                                                                                                                                                | Changes to the ABFM exam are not being considered at this time. |
exam by using national study of care content in family medicine practices.

- Providing feedback to residents and practicing physicians about the “anatomy” of the exam and their particular knowledge gaps. Effort has resulted in significant improvement in passing rates and improved feedback regarding relevance.

**Internal Medicine (ABIM)**

- Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.
- Introduced grace period for physicians to retry assessments for additional study and preparation if initially unsuccessful.

In 2018, the ABIM plans to offer two assessment options:

1) Certified physicians (Internal Medicine and Nephrology with more specialties to roll out in 2019 and 2020) will be eligible to take the Knowledge Check-In, a new two-year open-book (access to UpToDate®) assessment with immediate performance feedback. Assessments can be taken at the physician’s home or office, or at a computer testing facility instead of taking the long-form exam every 10 years at a testing facility. Those who meet a performance standard on shorter assessments will not need to take the 10-year exam again to remain certified.

2) Diplomates can also choose to take a long-form assessment given every 10 years. This option is the same as the current 10-year exam, but it will include open-book access (to UpToDate®) that physicians requested.

*ABIM is also working with specialty societies to explore the development of collaborative pathways through which physicians can maintain board certification.*

**Medical Genetics and Genomics¹ (ABMGG)**

Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years.

Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.

**Neurological Surgery (ABNS)**

- The 10-year secure exam can be taken from any computer, i.e., in the diplomate’s office or home. Access to reference materials is not restricted; it is an open book exam.
- On applying to take the exam, a diplomate must assign a person to be his or her proctor. Prior to the exam, that

In 2018, an adaptive MOC cognitive learning tool will be available:

- The tool will consist of updated knowledge that has evolved since the diplomate’s last certification, and the tool will be shorter, relevant, and more focused than the prior exam.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuclear Medicine (ABNM)</td>
<td><strong>Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.</strong> Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.</td>
</tr>
<tr>
<td>Obstetrics and Gynecology (ABOG)</td>
<td>The secure, external assessment is offered in the last year of each ABOG diplomate’s six-year cycle in a modular test format, and they are allowed to choose two selections that are the most relevant to their current practice. Studying the results of a pilot program launched in 2016 and 2017 to integrate the self-assessment and external assessment MOC requirements which allowed diplomates to continuously demonstrate their knowledge of the specialty. The pilot allowed diplomates to earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first five years of the self-assessment program.</td>
</tr>
<tr>
<td>Ophthalmology (ABO)</td>
<td><strong>Quarterly Questions™ replacing DOCK (high-stakes, 10-year) exam with longitudinal assessment program.</strong> In 2019, Quarterly Questions™ will replace the DOCK Examination for all diplomates.</td>
</tr>
<tr>
<td>Orthopaedic Surgery (ABOS)</td>
<td><strong>Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July. Diplomates without subspecialty certifications are allowed to take</strong> Piloting a virtual practice evaluation to evaluate diplomates on their own cases without requiring travel. Diplomates must submit medical records on 12 selected cases similar to an oral exam with the exam performed in a virtual platform.</td>
</tr>
</tbody>
</table>
| Practice-profiled exams in orthopaedic sports medicine and surgery of the hand.  
| • General orthopaedic questions were eliminated from the practice-profiled exams so diplomates are only tested in areas relevant to their practice.  
| • Detailed blueprints are being produced for all exams to provide additional information for candidates to prepare for and complete the exams.  
| • Eight different practice-profiled exams offered to allow assessment in the diplomate’s practice area. |
| Otolaryngology\(^1\) (ABOTO)  
aboto.org | Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. | Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam. |
| Pathology\(^1\) (ABPath)  
abpath.org | • Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August).  
| • Remote computer exams can be taken anytime 24/7 that the physician chooses during the assigned two-week period (spring and fall) from their home or office.  
| • Physicians are allowed to choose from more than 90 modules, covering numerous practice areas for a practice-relevant assessment.  

*Diplomates must pass the exam once every 10 years.* | Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.\(^1\) |
| Pediatrics (ABP)  
abp.org | 1) Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.  
2) Piloting Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), a new testing platform with shorter and more frequent assessments that include:  
• A series of questions released through mobile devices or a web browser at regular intervals.  
• Twenty multiple choice questions that are available quarterly and may be answered anytime during the quarter.  
• Immediate feedback and references.  
• Resources (i.e., internet, books) that can be used when taking the exam.  
• Allows for questions to be tailored to the pediatrician’s practice profile.  

*In 2019, MOCA-Peds will roll out to all certified pediatricians in subsequent years. Those who wish to continue taking the exam once every five years in a secure testing facility will still be able to do so.* |
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Description</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Medicine and Rehabilitation (ABPMR)</td>
<td>- Physicians will provide feedback on individual questions so the exam can be continuously improved.</td>
<td>Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.</td>
</tr>
<tr>
<td>Plastic Surgery (ABPS)</td>
<td>- Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</td>
<td>Piloting online delivery of MOC exam in place of centralized in-person testing center to reduce costs and time away from practice. Diplomates will be given immediate feedback on answers and offered an opportunity to respond again. If successful, this pilot may replace the high-stakes exam.</td>
</tr>
<tr>
<td>Preventive Medicine (ABPM)</td>
<td>In-person, pencil-and-paper, secure exam administered at secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion).</td>
<td>Changes to the ABPM exam are not being considered at this time.</td>
</tr>
<tr>
<td>Psychiatry and Neurology (ABPN)</td>
<td>- Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</td>
<td>Implementing a Part III pilot program to allow physicians who read lifelong learning articles and demonstrate learning by high performance on the questions accompanying the article, to earn exemption from the 10-year MOC high-stakes exam.</td>
</tr>
<tr>
<td>Radiology (ABR)</td>
<td>Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</td>
<td>Developing a pilot that may replace the current 10-year traditional exam, with an Online Longitudinal Assessment (OLA) model that will be piloted and include modern and more relevant adult learning concepts to provide psychometrically valid sampling of the</td>
</tr>
<tr>
<td>Diplomate’s knowledge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diplomates will create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diplomates will receive weekly emails with links to questions relevant to their registered practice profile.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diplomates will learn immediately whether they answered correctly or not and will be presented with the question’s rationale, a critique of the answers, and brief educational material.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgery (ABS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>absurgery.org</strong></td>
</tr>
<tr>
<td>• Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</td>
</tr>
<tr>
<td>• Transparent exam content, with outlines, available on the ABS website and regularly updated.</td>
</tr>
<tr>
<td>• Coordinating with the American College of Surgeons and other organizations to ensure available study materials align with exam content.</td>
</tr>
</tbody>
</table>

| In 2018, the ABS will begin offering shorter, more frequent, open-book, modular, lower-stakes assessments required every two years in place of the high-stakes exam. The new assessment is being introduced for general surgery, with other ABS specialties launching over the next few years. For 2018, diplomates will select from four practice-related areas: general surgery, abdomen, alimentary tract, or breast. More areas are planned for the future based on feedback from diplomates and surgical societies. Diplomates will take the assessment through their own computer at a time and place of their choosing within the assessment window, be provided with immediate feedback, and have two opportunities to answer a question correctly. |

<table>
<thead>
<tr>
<th>Thoracic Surgery (ABTS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>abts.org</strong></td>
</tr>
<tr>
<td>• Remote, secure, computer-based exams can be taken any time 24/7 that the physician chooses during the assigned two-month period (September-October) from their home or office. Diplomates must pass the exam once every 10 years.</td>
</tr>
<tr>
<td>• Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.</td>
</tr>
</tbody>
</table>

| The ABTS developed a web-based self-assessment tool (SESATS) that includes all exam material, instant access to questions, critiques, abstracts and references. |
Urology (ABU)  
abu.org

- Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.
- Clinical management emphasized on the exam. Questions are derived from the American Urological Association (AUA) Self-Assessment Study Program booklets from the past five years, AUA Guidelines, and AUA Updates.
- Diplomates required to take the 40-question core module on general urology, and choose one of four 35-question content specific modules.
- ABU provides increased feedback to reinforce areas of knowledge deficiency.

*The information in this table is sourced from ABMS Member Board websites and is current as of March 27, 2018.

1Seven ABMS member boards are utilizing CertLink™, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment pilots, some of which launched in 2017. More information is available at: abms.org/news-events/american-board-of-medical-specialties-announces-development-of-new-web-based-platform/ (accessed 1-8-18).
APPENDIX

CURRENT AMA POLICIES RELATED TO MOC AND OCC

H-275.924, “Maintenance of Certification”
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomat's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in MOC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.


D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification”

Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.

H-275.926, “Medical Specialty Board Certification Standards”
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic
Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.

3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.

5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

REFERENCES


12. The results are in: pilot testers give MOCA-PEDS "Thumbs up." The American Board of Pediatrics – BLOG. Available at: blog.abp.org/blog/moc-secure-exam-pilot-alternative-gets-thumbs-up (accessed 2-8-18).


38. Wynia MK. The Role of Professionalism and Self-regulation in Detecting Impaired or Incompetent Physicians. JAMA. 2010;304(2):210-211.
EXECUTIVE SUMMARY

Over the past ten years the establishment of new medical schools and the expansion in class size of existing medical schools has helped create a growing physician workforce, which is considered essential to providing health care to a growing and aging patient population. This expansion, however, has also created a perceived “bottleneck” in the transition from medical school to residency training, as the growth of entry-level residency training positions has not been commensurate with the increase in the number of graduates. American Medical Association (AMA) Policy D-305.967 (31), “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” directs our AMA to “study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.” This report is in response to that directive.

Analysis of existing graduate medical education (GME) data and projections suggests that, while there will be continued growth of United States medical school graduates (USMGs), there is still substantial room for placement of USMGs into GME, with an excess of 4,500 positions relative to graduates for the next several years. Although there are more entry-level GME positions than USMGs, there are other physicians vying for these same training opportunities. Approximately half of international medical school graduates (IMGs), either U.S. citizens (US IMGs) or foreign nationals (non-US IMGs) participating in the National Resident Matching Program, successfully match into positions. As competition for the pool of positions grows, applicant behavior causes stress for both applicants and the programs to which they apply. Applicants apply to more programs, and program directors must vet an ever-increasing number of applicants.

This report:

• Provides an update on recent numbers of medical students, graduates, and residency positions
• Summarizes recent residency applicant behavior and results in terms of matching into residency programs
• Describes recent state and medical school efforts to expand GME positions
• Describes the AMA’s national SaveGME campaign

The report concludes with a discussion regarding a changing GME environment, suggestions to help allay the concerns of students about matching, and potential policy changes for medical schools to consider.
INTRODUCTION

American Medical Association (AMA) Policy D-305,967 (31), “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” directs our AMA to “study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.” This report is in response to this directive.

This portion of the policy was appended through Resolution 320-A-16, “Expanding GME Concurrently with UME,” which was introduced by the Resident and Fellow Section at the 2016 Annual Meeting of the AMA House of Delegates (HOD). Testimony before Reference Committee C during the HOD meeting was overwhelmingly in favor of Resolution 320-A-16. Multiple individuals noted that the number of new medical schools and enrollment in existing institutions have expanded substantially of late, without a corresponding increase in the number of entry-level graduate medical education (GME) positions. Concern was voiced that the number of U.S. seniors successfully completing their undergraduate medical education (UME) at either allopathic or osteopathic medical schools likely will approach or surpass the total number of available U.S. GME positions within the next one to two decades. It was further acknowledged that the Accreditation Council for Graduate Medical Education (ACGME) is examining this important issue, with discussions that consider mitigating barriers to establishing training programs in specialties and locations that are underserved. Some testimony requested the addition of a second resolve to ask the AMA to advocate for expansion in resident and fellowship positions in proportion to expansions in medical school student populations and the health needs of the populace. Other testimony proposed limiting the number of U.S. medical school graduates (USMGs) per year. Additional discussion referenced the need for a national workforce plan that appropriately addresses specialty and geographic shortages. Testimony in opposition to the addition of the proposed second resolve focused on concerns that advocating for U.S. medical schools to limit class sizes could be construed as restraint of trade. Both the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) have the authority to set standards for schools, but they must approve any school that meets those standards; they cannot arbitrarily prohibit the establishment of new schools. While medical schools may have a moral obligation to consider the issue of the narrowing gap between the number of USMGs and the number of residency positions, it is not a legal obligation.

This report: 1) provides an update on recent numbers of medical students, graduates, and residency positions; 2) summarizes recent residency applicant behavior and results in terms of matching into residency programs; 3) describes recent state and medical school efforts to expand GME positions; 4) describes the AMA’s national SaveGME campaign; and 5) concludes with a discussion.
Concerning a changing GME environment, recommendations to help allay student concern about matching, and potential policy changes for medical schools to consider.

BACKGROUND

Concerns regarding the number of GME positions available to medical school graduates, known as post-graduate year 1 (PGY1) positions, have been increasing over the past several years.

In 2006, the Association of American Medical Colleges (AAMC) issued a call for expanding the number of medical school graduates, due to data suggesting an imminent physician shortage. The AAMC recommended a 30 percent increase (over 2002–2003 levels) in first-year medical school enrollment in LCME-accredited schools by the 2015–2016 academic year. Using the baseline of the 2002–2003 first-year enrollment (16,488 students), a 30 percent increase corresponds to an increase of 4,946 students. The AAMC forecast in 2017 that the 30 percent goal would be attained by 2017-2018 and exceeded in future years.1 Osteopathic medical schools, which are accredited by COCA, also have grown in number and in the number of enrollees and graduates.2 The number of LCME- and COCA-accredited schools, first year enrollment, and corresponding allopathic and osteopathic graduates is presented in Table 1, at the end of this report.

The rate of growth in the number of USMGs currently is greater than the rate of growth in PGY1 positions. Analysis of existing data and projections suggests there is still substantial room for placement of USMGs into GME, with an excess of 4,500 positions relative to graduates, as shown in the Figure at the end of this report.3

One analysis found that 99% of U.S. MD graduates ultimately do find careers in medicine.5 The percent of U.S. MDs matching into PGY1 positions through the National Resident Matching Program (NRMP) has been consistently at 94% since at least 2008; only 500 to 600 U.S. MD graduates do not find a position through the NRMP’s Supplemental Offer and Acceptance Program (SOAP), which assists in placing unmatched applicants into unfilled positions.6 Other, infrequent opportunities exist post-SOAP for students to find positions in unfilled programs. Nonetheless, medical students continue to experience anxiety over the possibility of graduating from medical school without a training position, a necessary requirement for a clinical career in medicine.

Although there are more PGY1 positions than USMGs, it is important to consider that other physicians also are vying for these training opportunities. Approximately half of international medical school graduates (IMGs), either U.S. citizens (US IMGs) or foreign nationals (non-US IMGs) participating in the NRMP, successfully match. A much smaller proportion find positions through SOAP.

There are a number of reasons why USMGs do not match into PGY1 positions; the Council on Medical Education has written several recent reports on this topic (CME 3-A-16, “Addressing the Increasing Number of Unmatched Medical Students,” and CME 5-A-17, “Options for Unmatched Medical Students”). One contributing factor is that not all positions are equally desirable to every applicant because of specialty and practice location preferences. For example, an average overall growth rate of two percent does not necessarily mean that there are enough positions in dermatology for all the applicants who wish to train in dermatology or wish to train in dermatology in the state of Georgia. The apprehension born of the perception of fewer available positions, often misreported in the popular press,7 is coupled with a sense of increasing competitiveness, which may be caused in part by the increase in the number of DOs participating in the NRMP (in the 2013 Match, DOs made up 7.9 percent of matched applicants, versus 10.6 percent in 2017). The number of osteopathic students choosing to match into allopathic programs via the NRMP was increasing...
even before the transition to the Single Accreditation System, through which the ACGME will
accredit both allopathic and osteopathic programs. This increase will continue during the transition
of osteopathic program positions into the NRMP, which will be completed in July 2020.

One of the unintended consequences of this perceived bottleneck is that residency applicants have
increased their number of program applications in an attempt to improve the likelihood of receiving
an invitation to interview and eventually secure a residency. Table 2, at the end of this report,
provides the average number of program applications per applicant through the Electronic
Residency Application Service (ERAS) and the average number of applications received by
programs. An NRMP analysis of U.S. MD seniors participating in the 2017 Match in the 20 largest
specialties found that MD seniors who ultimately successfully matched applied to a median number
of 35 programs, resulting in a median number of 16 offered interviews. MD seniors who ultimately
did not match applied to a median number of 54 programs, resulting in a median number of six
offered interviews.8 Data from the 2013 Match shows comparable numbers: successfully matched
MD seniors applied to a median number of 29 programs, yielding 15 interview offers. Unmatched
MD seniors applied to a median number of 50 programs, yielding seven interview offers.9 These
data suggest that simply applying to more programs does not necessarily result in more interview
opportunities. In addition, analyses by the AAMC provide information on the point of diminishing
returns in the number of applications sent by U.S. MD applicants, by USMLE Step 1 score and
specialty.10

STATE AND MEDICAL SCHOOL EFFORTS

Recently, some individual schools, medical systems, and states have begun to address the
discrepancy between rapidly expanding UME enrollment and GME expansion, often in tandem
with efforts to meet the health care needs of local populations.

Texas

In 2017, the Texas state legislature passed Bill 1066, “Requirement to Plan GME Needs in
Conjunction with Medical School Planning,” which requires that all new public allopathic and
osteopathic medical schools in the state provide to the Texas Higher Education Coordinating Board
an assessment of the adequacy of the projected number of first-year residency positions that may be
available for graduates of the new medical school. If a shortage is projected, the medical school
will be required to submit a plan to increase the number of PGY1 positions in the state to
reasonably accommodate the number of graduates from all MD and DO medical school programs
in Texas and “provide adequate opportunity for those graduates to remain in the state for the
clinical portion of their education.” Submission of the assessment, and, if necessary, the plan to
increase PGY1 positions, is a prerequisite for the board’s approval of the medical school.11

Not only does this bill serve Texas’s needs by ensuring UME expansion within the state is coupled
with GME expansion, allowing newly graduated physicians the opportunity to remain in Texas for
their training, but it also establishes a legislative strategy to assure UME expansion is coupled with
theoretical opportunity to complete GME training in the state. It does not, however, address the expansion of
already existing medical schools. The law also does not affect future planned private medical
schools. In addition, although the plan must specify that there will be adequate PGY1 positions in
the state, the proposed medical school itself is not required to sponsor the GME programs. The plan
regards total state numbers, not type of program or location, and is not specific to an institution. If
the state’s total number of existing residency positions is expected to meet the needs of the total
number of medical school graduates, the medical school does not have to submit a plan for
developing additional GME positions.

The Texas Medical Association (TMA) is working to address a loophole in the current law. New
medical schools are required to submit a GME plan to demonstrate the projected availability of
training positions for the total number of students in the inaugural class. Most schools, however,
start with a relatively small number in the inaugural class, with plans to expand the class size after
achieving full accreditation status. The result is that the full GME needs of their students are
neither identified nor planned for from the beginning. The TMA will likely consider a proposed
amendment that would stipulate that medical schools must submit a plan to meet the GME needs
for the school’s planned target class-size.

Kaiser Permanente

Kaiser Permanente, a large, integrated, population-based health care delivery system in the Western
U.S., has been one of the largest private contributors to GME funding through its integrated
residency programs. Kaiser currently hosts residency positions in five regions (Northern and
Southern California, the Pacific Northwest, Colorado, and Hawaii). These collective programs
support 900 full-time equivalents of residents in over 30 specialties. Residents in the Kaiser
Permanente system are hosted primarily through Kaiser itself (600 residents), but affiliate programs
also send residents to train within the Kaiser system for some duration of time. In total, 3,000
individuals per year rotate through the Kaiser system for training. Kaiser has been very successful
in retaining trainees following completion of residency training, with one-third to one-half of
trainees staying and practicing in the Kaiser system. Savings on physician recruitment are then
used to support Kaiser’s resident complement.

Following its success in establishing diverse and sustainable residency training positions, Kaiser is
building a medical school in Southern California. The inaugural class of 2019 is expected to have
48 students, with a full complement of 192 enrolled by 2022. Initial plans for student education
include early exposure to patients and integration into the robust network of clinical opportunities
available within the Kaiser system.

Local assistance

Creating a new GME program from scratch is a daunting process, but more information has
become available about the process. Consultants with GME experience are available to assist. One
institution recently published a plan for starting a new residency program, with step-by-step
guidelines. The state of Indiana has worked with at least two consultant groups to develop its plan
to expand GME.

SAVEGME CAMPAIGN

The AMA has long advocated for both the preservation of GME funding and additional monies to
support future physician workforce needs, as noted in, for example, Council on Medical Education
Report 5-A-16, “Accountability and Transparency in Graduate Medical Education Funding.” The
SaveGME website (savegme.org), originally oriented toward medical students and physicians, was
revamped with a public-facing aspect in 2017. The revitalized website was then shared across
social media platforms and various advocacy groups including the Patients Action Network and the
Physicians Grassroots Network. This campaign emphasized the value of residents to patient care,
including the provision of 40 percent of charity care nationwide as well as the importance of
residency programs to innovations in health care delivery and patient safety initiatives. The new
website includes videos, statistics, demographics, and other material to support the SaveGME
campaign. From March through October 2017, there were 78,827 visits to the SaveGME.org
website and 1,816,821 video views. Social medial platforms proved useful in spreading the
message, with over 12.5 million impressions on Facebook and Twitter. Over 2,300 letters were sent
via the site to legislators by 720 individuals, representing a 16-fold increase compared to the year
prior in communication to legislators.17

CURRENT AMA POLICY

Currently, the AMA has several policies or directives that concern the lack of appropriate growth
in GME positions; these are listed in the Appendix.

SUMMARY

Without expansion in the number of PGY1 positions available to recently minted medical school
graduates, eventually the number of USMGs seeking positions will exceed what is available.
Lacking this expansion, some potential applicants likely will seek training elsewhere. Non-US
IMGs, a group that long has trained in the U.S. and greatly added to the U.S. physician workforce
in numbers and diversity, as well as specialty and geographic focus, may choose to train in other
countries where there are more opportunities and fewer immigration barriers (CME Report 3-I-17,
“Impact of Immigration Barriers on the Nation's Health”). The reduction in the size of one
applicant pool likely will prolong the period during which there is increasing competition for
positions, but still more available positions than USMGs. Despite this temporary reprieve, medical
students perceive increasing competition and suffer anxiety engendered by the risk of graduating
with substantial educational debt but without a residency position. Medical schools should increase
their efforts to guide students concerning educational debt, specialty choice, and potential career
paths, in order to better prepare students entering a physician workforce that may have constraints
in its capacity to grow. In this context, and in anticipation of this country’s future health care needs,
efforts to expand UME without thoughtful provision of GME opportunities is careless at best and
negligent at worst.

RECOMMENDATIONS

The Council on Medical Education therefore recommends that the following recommendations be
adopted and the remainder of this report be filed.

   for Graduate Medical Education,” be rescinded, as having been fulfilled by this report.
   (Rescind HOD Policy)

2. That our American Medical Association (AMA) encourage all existing and planned
   allopathic and osteopathic medical schools to thoroughly research match statistics and
   other career placement metrics when developing career guidance plans. (Directive to Take
   Action)

3. That our AMA encourage legislators, private sector partnerships, and existing and planned
   osteopathic and allopathic medical schools to create and fund graduate medical education
   (GME) programs that can accommodate the equivalent number of additional medical
   school graduates. (Directive to Take Action)
That our AMA encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion. (Directive to Take Action)

Fiscal note: $1,000.
TABLE 1. MEDICAL SCHOOLS, FIRST YEAR ENROLLMENT, GRADUATES, AND
TRAINEES IN FIRST YEAR POSITIONS FOR ACADEMIC YEARS 2012-2013 THROUGH
2017-2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of allopathic medical schools†</td>
<td>136</td>
<td>140</td>
<td>141</td>
<td>142</td>
<td>145</td>
<td>147</td>
</tr>
<tr>
<td>Number of colleges of osteopathic medicine‡</td>
<td>26</td>
<td>29</td>
<td>29</td>
<td>30</td>
<td>36</td>
<td>48</td>
</tr>
<tr>
<td>MD 1st-Year Enrollment†</td>
<td>20048</td>
<td>20583</td>
<td>20608</td>
<td>21128</td>
<td>21396</td>
<td>21338*</td>
</tr>
<tr>
<td>DO 1st-Year Enrollment‡</td>
<td>5986</td>
<td>6636</td>
<td>7012</td>
<td>7219</td>
<td>7575</td>
<td>8113</td>
</tr>
<tr>
<td>MD Graduates†</td>
<td>18147</td>
<td>18057</td>
<td>18668</td>
<td>18820</td>
<td>19402¥</td>
<td></td>
</tr>
<tr>
<td>DO Graduates‡</td>
<td>4806</td>
<td>4997</td>
<td>5323</td>
<td>5472</td>
<td>6038</td>
<td></td>
</tr>
<tr>
<td>Total U.S. Graduates</td>
<td>22953</td>
<td>23054</td>
<td>23991</td>
<td>24292</td>
<td>25440</td>
<td></td>
</tr>
<tr>
<td>Annual Graduate Growth Rate (%)</td>
<td>.44</td>
<td>4.06</td>
<td>1.25</td>
<td>4.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PGY1 Applicants Matched in NRMP∞</td>
<td>25246</td>
<td>25687</td>
<td>26252</td>
<td>26836</td>
<td>27688</td>
<td>29040</td>
</tr>
<tr>
<td>Residents in ACGME PGY1 Positions₤</td>
<td>26018</td>
<td>26649</td>
<td>27122</td>
<td>27949</td>
<td>28658</td>
<td></td>
</tr>
<tr>
<td>Annual ACGME PGY1 Growth Rate (%)</td>
<td>2.42</td>
<td>1.77</td>
<td>3.05</td>
<td>2.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applicants Matched in NMS (Osteopathic Match)§</td>
<td>1891</td>
<td>2022</td>
<td>2135</td>
<td>2206</td>
<td>2162</td>
<td>1640</td>
</tr>
<tr>
<td>Annual Osteopathic Match Growth Rate (%)</td>
<td>6.93</td>
<td>5.59</td>
<td>3.32</td>
<td>-1.99</td>
<td>-24.14</td>
<td></td>
</tr>
</tbody>
</table>

† LCME database, includes schools with first year enrollment.
¥ LCME database; schools estimated the number of graduates in February 2017.
TABLE 2. AVERAGE NUMBER OF APPLICATIONS THROUGH ERAS FOR ACADEMIC YEARS 2013-2014 THROUGH 2017-2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>USMG</td>
<td>43.8</td>
<td>47.2</td>
<td>49.3</td>
<td>55.0</td>
<td>58.0</td>
</tr>
<tr>
<td>IMG</td>
<td>113.4</td>
<td>119.1</td>
<td>123.1</td>
<td>131.5</td>
<td>135.5</td>
</tr>
<tr>
<td>All applicants</td>
<td>74.3</td>
<td>78.6</td>
<td>80.7</td>
<td>87.7</td>
<td>90.1</td>
</tr>
<tr>
<td>Average number of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>applications sent by</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>applicant*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>USMG</td>
<td>285.9</td>
<td>306.6</td>
<td>327.9</td>
<td>367.2</td>
<td>386.8</td>
</tr>
<tr>
<td>IMG</td>
<td>576.6</td>
<td>601.5</td>
<td>606.3</td>
<td>654.3</td>
<td>639.5</td>
</tr>
<tr>
<td>All applicants</td>
<td>862.2</td>
<td>907.8</td>
<td>933.9</td>
<td>1021.1</td>
<td>1025.7</td>
</tr>
<tr>
<td>Average number of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>applications received</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>by program**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*https://www.aamc.org/download/359232/data/all.pdf Accessed August 15, 2017. USMG includes U.S. MDs and DOs, of any graduating class.

**https://www.aamc.org/download/359236/data/all.pdf Accessed October 13, 2017. USMG includes U.S. MDs and DOs, of any graduating class.
FIGURE

Actual and Projected Growth in Numbers of U.S. Medical School Graduates and Graduate Medical Education (GME) Entrants, Based on 1.66% Annual Growth in GME Positions.

APPENDIX: RELEVANT AMA POLICY

D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education”
Our AMA will: (3) Actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997); (4) Strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation; (8) Vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME; (15) Encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site; (17) Work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region; (18) Supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes; (26) Encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

D-305.958, “Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy”
Our AMA will: (2) Work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US; (3) Work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997; (4) Actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages; (5) Lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.

H-310.917, “Securing Funding for Graduate Medical Education”
Our AMA: (4) Encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

H-305.988, “Cost and Financing of Medical Education and Availability of First-Year Residency Positions”
Our AMA: (2) In studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future.

H-465.988, “Educational Strategies for Meeting Rural Health Physician Shortage”
Our AMA: (2) Encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
H-200.954, “US Physician Shortage”
Our AMA will: (8) Continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification; (9) Work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.

D-310.977, “National Resident Matching Program Reform”
Our AMA: (11) Will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs; (15) Encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.
REFERENCES

1 Association of American Medical Colleges. 2017. Results of the 2016 Medical School Enrollment Survey. Washington, DC.


6 NRMP Update. Group on Student Affairs, April 2017.


8 NRMP, Data Release and Research Committee: Results of the 2017 NRMP Applicant Survey by Preferred Specialty and Applicant Type. National Resident Matching Program, Washington, DC. 2017

9 NRMP, Data Release and Research Committee: Results of the 2013 NRMP Applicant Survey by Preferred Specialty and Applicant Type. National Resident Matching Program, Washington, DC. 2013.


EXECUTIVE SUMMARY

Widespread concern exists related to the quality of clinical documentation training provided to medical students and residents. American Medical Association (AMA) Policy D-295.314, “Study of Current Trends in Clinical Documentation,” consequently directs our AMA to “study the effectiveness of current graduate and undergraduate education training processes on clinical documentation.” A primary concern is that many medical students lack sufficient access to their training institution’s electronic health record (EHR) system. Although the medical education community agrees that it is essential that students become familiar with clinical documentation and the EHR, some institutions restrict access to the EHR because of potential legal liability related to the risk of errors made by students’ ability to copy and paste notes. Residents generally have adequate access to their institution’s EHR, although there remain concerns about the adequacy of the clinical documentation training they receive. There are also concerns about the effects of the EHR on student- or resident-patient relationships, in that students or residents may be more engaged with the chart and computer than with the patient. In addition, students may receive poor role modeling from faculty, as well as from the entire care team, on appropriate use of and best practices for EHRs.

This report describes:

- Literature concerning the quality of clinical documentation and effects on patient care and safety, as well as reimbursement;
- Training and evaluation of training in incorporating the EHR into the physician/patient encounter in undergraduate and graduate medical education;
- Training and assessment of training of clinical documentation accuracy in undergraduate and graduate medical education; and
- Relevant work of the Accelerating Change in Medical Education Consortium.

A literature review on training for incorporation of the EHR into the physician/patient encounter and of the accuracy of clinical documentation in the EHR reveals that few published research studies are constructed to provide a useful evaluation of training results. Fewer studies provide a reflection upon the value and effectiveness of the training provided. It therefore is difficult to provide a conclusive summary of the most effective manner in which to train medical students and residents on the EHR. Confounding and uncontrollable circumstances are always a risk in evaluation of educational programs occurring in natural settings. Additionally, as many institutions and medical schools use their own clinical documentation systems or have modified an “off-the-shelf” system, results can be hard to generalize to other settings.

This report includes recommendations to encourage EHR training that includes feedback on the value and effectiveness of the training and that is demonstrated to be useful in clinical practice. In addition, the report recommends that professional development resources be made available to faculty to assure appropriate modeling of EHR use during physician/patient interactions.
REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-18

Subject: Evaluation of Clinical Documentation Training

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee C
(Sherri S. Baker, MD, Chair)

INTRODUCTION


This policy stemmed from Resolution 702-A-16, introduced by the Medical Student Section. Testimony before Reference Committee C during the Annual 2016 Meeting of the AMA House of Delegates highlighted the unprepared state of many medical school graduates for effective clinical note-taking, which could result in inaccurate notes and potentially negative patient outcomes. This report, which is in response to Policy D-295.314, will: 1) describe concerns about quality in clinical documentation and effects on patient care and safety, as well as reimbursement; 2) describe training and evaluation of training in incorporating the electronic health record into the physician/patient encounter in undergraduate and graduate medical education; 3) describe training and assessment of training of clinical documentation accuracy in undergraduate and graduate medical education; and 4) summarize relevant work of the Accelerating Change in Medical Education Consortium.

BACKGROUND

Concerns about clinical documentation proficiency of medical students and residents

There has been widespread concern about the quality of clinical documentation of physicians, focusing on the training provided medical students and residents. A primary concern is that many medical students lack sufficient access to their training institution’s electronic health record (EHR) system. (Note: Much of the literature uses either the term electronic medical record or electronic health record. This report will use the term EHR for both terms.)

Medical students’ inconsistent access to the EHR can result in students graduating without well-developed skills, forcing first-year residents to spend time familiarizing themselves with the EHR while they are learning to care for patients for the first time without direct supervision. Although the medical education community agrees that it is essential for students to become familiar with documentation and the EHR, some institutions restrict access to the EHR because of potential legal liability related to the risk of errors made by students’ ability to copy and paste notes in the EHR. In addition, the Centers for Medicare & Medicaid Services (CMS) has rules regarding the use of student documentation to support billing for services which, if not followed, can add potential legal liability.
To prevent institutions from running afoul of CMS rules, the Association of American Medical Colleges has recommended that EHR systems include rigorous controls to safeguard physicians from inadvertently copy/pasting a note created by a medical student, which would have been out of compliance with CMS payment regulations. Until recently, if a student documented an evaluation and management service (E/M), the teaching physician had to verify and re-document the physical examination and the medical decision-making activities of the services. The physician could only refer to a student’s documentation related to the review of system and/or past/family and/or social history.² Beginning in March 2018, CMS “allows the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work.” As CMS notes, however, “the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.”³ While this update in policy may encourage some medical schools and clinical teaching sites to allow more medical students to access the EHR, institutions are advised, as a best practice, to “[i]nvest in provider education to create high-quality documentation with EHR tools.”⁴

Students’ use of copy and paste functions (CPF) in the EHR is widespread and has raised concerns about potential lapses in patient quality of care and medical ethics. Third-year medical students at one medical school were surveyed about their use of CPF in the EHR, as well as observations of other professionals using CPF. All students frequently used the EHR for documenting their patient notes. Although very few (10 percent) believed it acceptable to copy and paste from other providers’ notes, 83 percent believed it acceptable to copy and paste from their own notes, 22 percent have copied from residents’ notes, and 13 percent have copied from attendings’ notes. Although using CPF is a common practice, 46 percent believed that notes written using CPF are less accurate than notes written without it, and 45 percent believed that CPF causes problems in patient care. Only 42 percent of students were aware of their school’s policy concerning copy and paste (students are prohibited from copying others’ notes, but are permitted to copy their own note from a previous day if it is altered to reflect the patient’s current condition).⁵

Besides concerns about inappropriate use of CPF in the EHR by medical students, clerkship directors worry about the effect of the EHR on student-patient relationships, in that students are more engaged with the chart and computer than with the patient. In addition, students are receiving poor role modeling from faculty, as well as from the whole care team, on appropriate use of and best practices for EHRs.⁶

Similar concerns are also relevant when reviewing residents’ use of the EHR. In a survey at a large integrated health system, program directors were questioned about their confidence in their first-year residents’ abilities to perform 13 core entrustable professional activities (EPAs) six months into their first year of training. Overall, 62 percent of their residents were assessed. Confidence in the residents’ ability to perform the activities without supervision ranged from 38 percent to 98 percent. Sixty-nine percent of first-year residents were considered to be able to perform EPA 4, “Enter and discuss orders and prescriptions,” without supervision, while 98 percent were considered able to document a clinical encounter in the patient record without supervision.⁷

Although residents have been found to make fewer errors than attending physicians in the EHR, at least at the time of transition from paper to electronic documentation,⁸ other research has pointed out the need for education in clinical documentation and coding practices for residents. A retrospective chart review in 2014 of surgery residents at one institution found 28 percent of the reviewed charts had inaccuracies in one or more of the following categories: admission diagnoses,
surgical diagnoses, in-hospital complications, or comorbidities. The average reimbursement of the charts with inaccuracies was $7,849 compared to $8,418 for the corrected versions, a 12.4 percent difference. The authors suggest that hospitals may incur significant loss in revenue due to errors in clinical documentation by residents and that educational training for surgical residents in clinical documentation and hospital-specific coding practices could prove financially advantageous.9

Published literature describing training in clinical documentation accuracy in the EHR and the use of the EHR and computers during the physician/patient encounter is relatively rare, especially given the concerns that clinical documentation inaccuracy and poor physician/patient interactions can affect patient care and safety.

TRAINING IN AND ASSESSMENT OF THE EHR IN THE PHYSICIAN/PATIENT ENCOUNTER

In 2012, the Alliance for Clinical Education, a consortium of clerkship directors across clinical disciplines, published guidelines for medical student documentation in the EHR.10 These guidelines note the importance of students becoming competent in EHR use prior to graduation and acknowledged that such education is infrequent. The final guideline states that medical schools should develop competencies for charting in the EHR and state how these competencies would be evaluated. The guidelines lay out opportunities for EHR training throughout the curriculum, providing a framework for institutions developing such curriculum for their students. Wald and colleagues have also outlined curriculum objectives that could be incorporated into EHR training in undergraduate medical education.11

In 2014, Hersh and colleagues outlined competencies across the content of clinical informatics for medical education. These included several competencies related to EHR use, which they have begun implementing for their students at Oregon Health & Science University School of Medicine (OHSU), a member of the Accelerating Change in Medical Education Consortium.12

Overall, in both undergraduate and graduate medical education, there is broad support for increased education and training in the use of the EHR. Several expert groups have recommended specific objectives and competencies for such curricula. However, there are fewer reports of implementation of these curricula and assessment of their outcomes. Few studies have been conducted to examine the effectiveness of training in the use of the EHR in encounters between medical students/residents and patients. Often studies in educational environments lack the ability to control confounding factors; enroll enough participants; and include objective, third-party observers.

Assessment of training provided for medical students

OHSU has been one of the leaders in introducing medical students to the EHR as part of an objective structured clinical examination (OSCE). During the OSCE, the student interacts with a standardized patient (SP) and accesses a simulated EHR. The student’s performance is evaluated by a faculty member either in the room or behind a two-way mirror. The EHR-OSCE assesses EHR skills rather than medical knowledge, which include not only what information is placed into the EHR but also the positioning of the computer/monitor throughout the examination.

The University of Texas Health Science Center at San Antonio (UTHSCSA) has adopted the OHSU EHR-OSCE. Although not designed to evaluate the effectiveness of EHR training, a paper comparing the performance of students of the two schools suggests that some differences in performance may be the result of the timing of the training. Students from UTHSCSA had better
overall performance compared to OHSU students. In particular, UTHSCSA students’ performance improved over the course of the year, while OHSU students’ EHR skills failed to improve as the year progressed. UTHSCSA students received didactic EHR training in the weeks immediately preceding the OSCE, while OHSU students received training up to 14 months prior to the OSCE. The authors of the study suggest that this intervening period at OHSU caused EHR skills to atrophy and also increased students’ exposure to negative role-modeling while observing clinicians using the EHR.

Han, Waters, and Loop designed a study to measure the effectiveness of an online self-study module for medical students and other health care professionals. The module includes sections on education, computer placement, and provider-patient interactions in the presence of the EHR. The module emphasizes the potential of using the computer as a visual aid in patient education, along with appropriate placement of the computer to promote a positive open triadic position, and presents methods to maximize the provider-patient relationship while involving the patient in the EHR process. The researchers were able to use SP encounter videos of medical students before the introduction of the module into the second year curriculum as a pre-test and compared SP videos of students who completed the module. In addition, SP evaluations of the encounters were compared, and students were also reevaluated three months later. Students who had taken the module demonstrated better EHR communication skills compared to the pre-module students, SPs’ evaluations were more positive, and three months later students had retained their skills.

Educators at the University of Arizona College of Medicine - Phoenix assessed whether EHR ergonomics training enhances students’ ability to use the EHR during SP encounters. They compared the performance of students in three groups, all of whom took a pre-survey on computer use: 1) students who received two hours of basic EHR training and had no EHR available during SP encounters; 2) students who received the EHR training and were expected to use the EHR available during SP encounters; and 3) students who received the EHR training, were expected to use the EHR during SP encounters and received additional ergonomic training. Ergonomic assessment data were collected from students, faculty, and SPs in each session. A post-survey was administered to all students, and data were compared across all three groups to assess the impact of EHR use and ergonomic training. The results revealed a significant positive effect for the third group, in that EHR use improved with EHR ergonomic training—specifically, those who had the ergonomic training felt that they were able to use the EHR more effectively to engage with the patient, better articulate the benefits of using the EHR, better address patient concerns, more appropriately position the EHR device, and more effectively integrate the EHR into the patient encounter.

Assessment of training provided for residents

Fogarty, Winters, and Farah developed a workshop conducted with 139 residents and faculty supervisors on the challenges and opportunities of working with the EHR in practice, covering the introduction of patient-centered behaviors and presenting videos demonstrating common behaviors and improvements. Possibly exemplifying the difficulty of conducting research into educational innovations, only 39 of the 139 participants completed both the baseline and post-intervention assessment. In another study, a standardized, streamlined note template was added to the EHR at a free-standing children’s hospital. Comparing the notes written in the EHR with the template to notes written during the same time period a year earlier, notes using the template were statistically shorter and trainees finished their notes later in the day, although there were no differences in the total amount of time to write notes (238 vs. 225 minutes, p=.32). Overall, the standardized note template was well-received by residents, despite some ambivalence about EHR functionality. As
another possible example of the difficulty of research in these settings, the authors point to an unexpected confounder of the study, i.e., more notes were written post-template implementation. This likely reflects an increase in the patient census and accompanying number of notes to be written without an increase in resident coverage.\textsuperscript{17}

Other research looked at a family medicine residency program that developed a longitudinal primary care medical home (PCMH) case-based EHR curriculum. The EHR training was grounded in clinical cases, including a step-by-step breakdown of the PCMH clinic visit, and delivered throughout the three-year residency program; residents were scheduled for a three-hour training session each trimester, with an EHR self-assessment of six core skills taken at the end of each session. Researchers compared the self-assessments of residents who attended more training (eight or more sessions, average=9) to those who attended fewer than eight (averaging 5.3 sessions). The results showed that low-exposed residents improved the most over time, and high-exposed residents reported overall higher post-test scores at training completion.\textsuperscript{18}

In another study at a family medicine residency program, 36 residents volunteered for random assignment into either a simulation-based training program or a lecture-based training group, which covered tips on using the EHR (such as “reserve templates for documentation,” “tell your patients what you’re doing while you’re doing it,” “look at your patients,” etc.). The study included a pre-test simulation of six SPs, a post-test simulation of another six SPs, and evaluation by physician observers and by SPs. No difference was found between the two groups. Both groups had improved in their use of the EHR as evaluated by physician observers and SPs, and the residents rated themselves as more competent in the post-training phase. The authors of the study postulate that the six pre-test simulated encounters provided a major training effect for volunteers motivated to learn.\textsuperscript{19}

**TRAINING IN AND ASSESSMENT OF CLINICAL DOCUMENTATION ACCURACY**

**Assessment of training provided for medical students**

Although there are studies documenting students’ use of the EHR and assessing accuracy, assessment of the training provided students is lacking or at least not available in the published literature. One study did make an interesting comparison of the level of accuracy in the EHR performance of 222 third-year medical students during their internal medicine clerkships and subsequent performance on their end-of-clerkship professionalism assessments versus their end-of-year gateway OSCE clinical skills scores for communication and history taking. Overall, 31 percent of students had one error in the EHR, and 13.5 percent had two to six errors. Most errors were in structured data entry. Error rate was correlated with poor performance as assessed at the end of clerkship. However, there was no assessment of the method by which the students learn the EHR, which was 15 online tutorials completed over 71 minutes.\textsuperscript{20}

One study underscores the ability of medical students to accurately use the EHR in that it describes students as credentialed trainers at one academic health center that underwent a transition from one EHR system to another. Six selected medical students went through a six-week course that included instruction on adult learning theory, change management, and conflict resolution. They were assessed through written and oral examinations with the EHR vendor and institutional training leaders. The students then trained over 1,000 providers during a two-month time period. The trainers were given extremely high marks on the post-training survey, averaging 3.93 on a 4-point Likert scale for both mastery of material and communication skills (4 being excellent, 1 being poor). The authors noted that the institution saved considerable money using in-house trainers while providing the students a valuable financial and career opportunity.\textsuperscript{21}
Assessment of training provided for residents

Researchers at OHSU assessed the 1.5-day training on its EHR system that internal medicine residents receive at the beginning of residency. Training included instruction on real-world task completion relevant to interns’ clinical practice. One month after this training, interns participated in a dedicated exercise to test their ability to perform a set of 28 defined EHR use-related competencies with the OHSU simulation version of the EHR. All interns were found to have missed at least one safety issue, and overall there was wide variation in the amount and quality of data imported to generate notes. The researchers concluded that the results highlight the inadequacies of standard EHR training in the setting of advanced EHR use for data acquisition and documentation and noted that simulation may also help inform EHR redesign by reflecting accurate use patterns.

An example of the difficulty of performing educational evaluation research in real-world settings is demonstrated by a study that attempted to compare the effect of two different interventions on the quality of EHR clinical documentation of internal medicine residents at two medical schools. The educational quality improvement intervention project did not improve the quality of clinical documentation. The authors noted that they were not able to combine the scores of residents at the two schools, leading to small sample sizes, and that one rater scored documentation much higher than other raters. Calibration did not occur beforehand.

Although another study at OHSU was designed to assess whether EHR simulation improves EHR use in an ICU by comparing residents who went through the simulation once to those who participated twice, what occurred between the two sessions may account for much of the improvement found. Specifically, after residents were given the EHR of a case study:

Participants … presented the case to a member of the study team and were graded on the number of patient safety issues identified. After the exercise, every participant underwent an immediate, standardized debriefing session on action items missed and received suggestions to improve their skills for EHR use. Beginning with the laboratory data, participants were shown the important trends in renal function and blood counts, as well as a tutorial regarding the graphing functions available. From there, assessment and evaluation of the medication administration report was completed, with discussion of appropriate dosing of medications and finding therapeutic drug monitoring assessments. This would be followed by reviewing vital signs, beginning with the most commonly used screen to assess vitals and using two other screens that display the same information in different contexts. Participants were shown possible customizability options and graphing functions within the vital signs pages as well as specific information found only in these screens. Next, participants would review ventilator data and discuss lung protective and low tidal volume ventilation, as well as how to assess appropriateness of an individual patient’s ventilator settings. Volume status and intake/output reports were then viewed and specific issues surrounding volume status in ARDS were discussed. Finally, participants were given time to ask questions, re-review any functions of the EHR, and discuss any concerns regarding participation in the simulation exercise.

Not surprisingly, given the thoroughness of the debriefing session, residents who then were presented a second case study, one to four weeks later, improved their rate of overall recognition of patient safety issues compared to the first case study (39.9 percent vs. 63.4 percent).

In another study, researchers designed an intervention bundle to improve pediatric resident progress notes written in an EHR and to establish the reliability of an audit tool used to evaluate notes (which is not typical of much of this type of research). The bundle consisted of establishing
Note-writing guidelines, developing a note template, and educating residents about the guidelines and using the template. The residents received classroom teaching about best practices and instruction in use of the template. Raters were trained to score notes through practice sessions during which they all scored the same note and compared findings. Overall, improvement was mixed, with reduced vital sign clutter and other visual clutter within the note, but no significant reduction in input/output clutter, lab clutter, or inclusion of the medication list.

Noting that much of clinical documentation training for medical students, residents, and practicing physicians lacks key constructs in self-efficacy, namely, vicarious learning (peer demonstration) and mastery (practice), researchers devised a study to improve clinical documentation quality that compared two different models of training. One model, provided to internal medicine residents, used two components of self-efficacy: 1) social persuasion, e.g., emphasizing the importance of complete and accurate documentation for patient welfare and providing feedback to participants based on performance on a clinical documentation quality pretest as well as participation in the training session and 2) psychological/emotional states, e.g., discussing frustrations physicians have complying with increasing regulation, the monetary impact of incomplete or inaccurate documentation, and time management issues, as well as providing dinner as part of the training. The other model, administered to another group of residents, included two additional components of self-efficacy: 3) vicarious experience, e.g., video recordings of physicians discussing documentation, including solutions to problems, examples of good documentation shared, and experiences of documentation during the first training session (the pretest) were shared and discussed during the second session and 4) mastery experience, e.g., each participant had the opportunity to accurately and correctly document diagnoses in five problem areas from 10 sample records. This study used sophisticated data analysis and concluded that training using all four components of self-efficacy showed substantially greater positive impact on improved clinical documentation and self-efficacy compared to the two-component training. This study was not using, it appears, an EHR as part of the training, but the training model could be modified to those systems and likely is currently in use.

WORK OF THE ACCELERATING CHANGE IN MEDICAL EDUCATION CONSORTIUM

To help fill gaps in medical education and as part of its larger strategic focus to improve the nation’s health, the AMA launched the “Accelerating Change in Medical Education” initiative in 2013. After awarding initial grants to 11 medical schools from across the country, the AMA brought these schools together to form the AMA Accelerating Change in Medical Education Consortium—a unique, innovative collaborative that allowed for the sharing and dissemination of groundbreaking ideas and projects. In 2016 the AMA awarded grants to another 21 schools. Today, the 32-member consortium, which represents almost one-fifth of allopathic and osteopathic medical schools, is delivering forward-thinking educational experiences to approximately 19,000 medical students—students who will provide care to a potential 33 million patients annually. As consortium members continue to implement bold ideas and demonstrate a deep commitment to creating the medical schools of the future, their solutions are being disseminated to the greater academic community. These pioneering efforts are facilitating the widespread adoption of new ideas. A number of schools in the consortium have taken the lead in finding new and inventive approaches to instructing students on the use of EHRs.

New York University School of Medicine (NYU), for example, has recently fully integrated teaching note-writing into its pre-clerkship “doctoring” course. What had initially been taught at the end of the course is now taught alongside other subjects, e.g., communication skills, cultural competency, clinical reasoning, and so forth. During the first week of school, first-year students begin writing notes with actual patients. At the end of each clerkship, clinical note-writing is now
included in the OSCE. Although there has been no formal evaluation, integration of note-writing into the pre-clerkship syllabus has enhanced note-writing performance in the clerkship phase of training and on the comprehensive clinical skills exam at the end of clerkships. (Ruth Crowe, MD, PhD, assistant professor, NYU Department of Medicine, personal communication).

Recognizing that many medical students are starting residency without the experience of working effectively with EHRs, the Indiana University School of Medicine and the Regenstrief Institute (RI) developed the Regenstrief EHR Clinical Learning Platform as part of the AMA’s “Accelerating Change in Medical Education” initiative. This virtual EHR was developed to ensure medical students and other health care trainees gain real-world experience using EHRs during their training. It includes over 11,000 real, pseudonymized patient records. Learners can search and access patient data, document patient encounters, enter individual/unique actions, see actions entered across practice settings, receive alerts, place orders, and pull logs and reports.

The platform is currently in use in six medical schools/medical education programs. Schools are able to control the type of content students can access, as well as how students use the information in the platform. Some schools grade students on their ability to use the system. Although the platform was not designed to instruct students on how to write a patient note, correct documentation can be taught depending upon how a particular course adopts the platform into its curriculum. The RI team is evaluating machine learning and natural language understanding technology for the evaluation of student documentation. The first phase of this study employs supervised machine learning techniques to hopefully classify notes into good, bad, and mediocre sets. If this first phase is successful, the intent of subsequent studies will be to create automated and meaningful student documentation evaluation. (Blaine Takesue, MD, Research Scientist, Regenstrief Institute, and assistant professor of clinical informatics, Indiana University School of Medicine, personal communication)

RELEVANT AMA POLICY

Policy H-310.953, “Practice Options and Skills Curriculum for Residents,” directs our AMA to “assist medical societies and residency programs in the development of model curricula for resident physicians and those entering practice regarding practice options and management skills, including information on CPT and ICD coding.”

Policy H-315.969, “Medical Student Access to Electronic Health Records,” states that our AMA: “(1) recognizes the educational benefits of medical student access to electronic health record (EHR) systems as part of their clinical training; (2) encourages medical schools, teaching hospitals, and physicians practices used for clinical education to utilize clinical information systems that permit students to both read and enter information into the EHR, as an important part of the patient care team contributing clinically relevant information; (3) encourages research on and the dissemination of available information about ways to overcome barriers and facilitate appropriate medical student access to EHRs and advocate to the Electronic Health Record Vendors Association that all Electronic Health Record vendors incorporate appropriate medical student access to EHRs; (4) supports medical student acquisition of hands-on experience in documenting patient encounters and entering clinical orders into patients’ electronic health records (EHRs), with appropriate supervision, as was the case with paper charting; (5) (A) will research the key elements recommended for an educational Electronic Health Record (EHR) platform; and (B) based on the research--including the outcomes from the Accelerating Change in Medical Education initiatives to integrate EHR-based instruction and assessment into undergraduate medical education--determine the characteristics of an ideal software system that should be incorporated for use in clinical settings at medical schools and teaching hospitals that offer EHR educational programs; (6)
encourage efforts to incorporate EHR training into undergraduate medical education, including the technical and ethical aspects of their use, under the appropriate level of supervision; and (7) will work with the Liaison Committee for Medical Education (LCME), AOA Commission on Osteopathic College Accreditation (COCA) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the nation’s medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care.”

SUMMARY AND RECOMMENDATIONS

A review of the published literature on training in incorporating the EHR into the physician/patient encounter, and in the accuracy of clinical documentation in the EHR, reveals that few published research studies are constructed so that they can provide a useful evaluation of the results of the training. Fewer studies provide a reflection upon the value and effectiveness of the training provided. Assessments and comparisons are made and likely future revisions are planned for the training programs, but that is not shared. It is therefore difficult to provide a conclusive summary of the most effective manner in which to train medical students and residents on the EHR. Confounding and uncontrollable circumstances are always a risk in evaluation of educational programs in the “real world.” In addition, as many institutions and medical schools use their own clinical documentation systems or have modified an “off-the-shelf” system, results can be hard to generalize to other settings.

Some general observations can be made, however:

1. Any training should provide students, residents, and physicians with institutional policy regarding copy and paste functions or any other functions that have local guidelines.

2. Ergonomic training in the use and placement of a computer during the physician/patient encounter can be effective and should not be neglected.

3. Basic study methodology should always be considered: Use theory to develop hypotheses, guide the research, and organize the data analysis. Timing can affect evaluation results; without practice, newly acquired skills will atrophy. Pre-test sessions are a form of training—the more provided, the greater the risk in seeing no differences between study groups. Small sample sizes and poor training of evaluators can lead to inconclusive findings. Incentives should be designed to reduce drop out of learners for post-training assessment. Employing only one measure of evaluation is inadequate. Evaluation should include more than trainees’ self-assessment; standardized patients and trained observers should also provide feedback. Expect volunteers in studies to be motivated to learn, whether in the control or intervention group. Be prepared to use post-hoc study controls, in case uncontrollable extraneous events affect results.

4. Studies utilizing simulation, OSCEs, standardized patients, one-on-one training, and a more “hands on” approach as part of the intervention generally appear to have better results. While peer instruction is important, the more opportunities trainees have to use the system themselves and receive immediate feedback, the better.

5. Publishing information on what does not work is just as helpful as providing information on what does work. Programs should use study results to “close the loop,” i.e., act on the results and make ongoing improvements.
The Council on Medical Education therefore recommends the following recommendations be adopted and the remainder of this report be filed.

1. That Policy D-295.314, “Study of Current Trends in Clinical Documentation,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

2. That our American Medical Association (AMA) encourage medical schools and residency programs to design clinical documentation and electronic health records (EHR) training that provides evaluative feedback regarding the value and effectiveness of the training, and, where necessary, make modifications to improve the training. (Directive to Take Action)

3. That our AMA encourage medical schools and residency programs to provide clinical documentation and EHR training that can be evaluated and demonstrated as useful in clinical practice. (Directive to Take Action)

4. That our AMA encourage medical schools and residency programs to provide EHR professional development resources for faculty to assure appropriate modeling of EHR use during physician/patient interactions. (Directive to Take Action)

Fiscal Note: $1,000.
REFERENCES


20 Ferenchick GS, Solomon D, Mohmand A, et all. Are students ready for meaningful use? Medical Education Online. 2013; 18: http://dx.doi.org/10.3402/meo.v18i0.22495


EXECUTIVE SUMMARY

Concern is growing among the profession and the public about physician and medical student depression, burnout, and suicide. Resolution 301-A-17, Resolve 3, “Mental Health Disclosures on Physician Licensing Applications,” introduced by the Resident and Fellow Section and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to amend Policy H-275.970, “Licensure Confidentiality,” to address this concern. The AMA has expressed strong support of physical and mental health care services for medical students and physicians, but there is a long-standing and deeply ingrained stigma endured by physicians seeking care for either physical or mental health issues, partly due to concerns of career and licensure implications. In addition to concern related to stigma, which is linked to deterred or deferred care seeking, there is a lack of understanding of impairment vs. illness.

This report considers concerns that have been raised about the presence and phrasing of questions on licensing applications related to current or past impairment. These questions may be discouraging physicians from seeking appropriate treatment because of fear of stigmatization, public disclosure, and the effect on one’s job due to licensing or credentialing concerns. Many medical and osteopathic licensing boards recognize that the manner in which they evaluate the fitness of potential licensees has the potential to create a barrier that prevents licensees from seeking help. Some state boards, such as the Oregon and Washington State Medical Boards, have taken steps to address these barriers. In addition, the Federation of State Medical Boards has established a Workgroup on Physician Wellness and Burnout. The workgroup is confronting the barriers physicians face in seeking treatment for symptoms of burnout related to the presence and phrasing of questions on licensing applications about mental health, substance abuse, and leave from practice. The workgroup is also seeking to draw an important distinction between physician “illness” and “impairment” as well as determine whether it is necessary for the medical boards to include probing questions about a physician applicant’s mental health on licensing applications in the interests of patient safety.

This report comprises:
• A review of the current licensure application process.
• Research that describes why some physicians may be discouraged from seeking treatment for mental health conditions.
• An interpretation and definition of “psychiatric conditions” and “impairment.”
• A summary of physician health programs’ reporting requirements.
• A summary of actions being taken at the national and state levels to evaluate physician wellness and burnout as well as confidentiality about seeking treatment for mental health conditions.
• A review of AMA policy on this topic.
• Proposed recommendations to current AMA policy to strengthen and streamline the AMA’s position on this important topic.
Subject: Mental Health Disclosures on Physician Licensing Applications  
(Resolution 301-A-17, Resolve 3)

Presented by: Lynne M. Kirk, MD, Chair

Referred to: Reference Committee C  
(Sherry S. Baker MD, Chair)

Resolution 301-A-17, Resolve 3, “Mental Health Disclosures on Physician Licensing Applications,” introduced by the Resident and Fellow Section and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to amend Policy H-275.970, “Licensure Confidentiality,” by addition and deletion to read as follows:

H-275.970, “Licensure Confidentiality”

The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician’s practice of medicine or presents a public health danger that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine. (Modify Current HOD Policy)

At the Annual 2017 Meeting of the AMA HOD, Reference Committee C heard supportive testimony on this item from a wide variety of stakeholders, reflecting growing concern among the profession and the public related to physician and medical student depression, burnout, and suicide. The AMA has expressed strong support of physical and mental health care services for medical students and physicians. Council on Medical Education Report 1-I-16, “Access to Confidential Health Services for Medical Students and Physicians,” addressed the long-standing and deeply ingrained stigma endured by physicians seeking care for physical or mental health issues, partly due to concerns of career and licensure implications. Despite several existing HOD policies that support this request, testimony reflected additional concerns related to stigma, deterred or deferred care seeking, and the belief that there is a lack of understanding of impairment vs. illness. For these reasons, the HOD recommended that Resolution 301, Resolve 3, be referred for further study.
BACKGROUND

The role of state medical and osteopathic boards and patient safety

Medical and osteopathic licensing boards are state governmental agencies responsible for granting licenses to physicians to practice in the state. The primary responsibility of the boards is to determine that physicians are maintaining and advancing their knowledge and skills and providing quality patient care. Boards are also responsible for protecting the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine. The boards do so by obtaining sufficient physician information to conduct rigorous and thorough application reviews before the practice of medicine is permitted.

The current licensure application processes

State medical licensing boards have traditionally made wide-ranging inquiries into applicants’ past psychiatric histories as part of the application process. Although the passage of the Americans with Disabilities Act (ADA) in 1990 raised serious doubts about the legality of these inquiries, the boards have been reluctant to abandon them, even though the American Bar Association and the American Psychiatric Association (APA) have since issued statements disapproving them.

Most initial and renewal medical licensure application forms include questions about mental health diagnoses or treatment, but there is substantial variation in reporting requirements among the boards. For example, while some applications inquire only about current (within the previous 12 months) impairment from a medical or mental health condition (e.g., “Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?”), others include questions about current or past diagnosis or treatment of a mental health condition (rather than current impairment from such a condition). Some states specifically inquire if the applicant has ever had a diagnosis of, or been treated for, bipolar disorder, schizophrenia, paranoia, or other psychotic disorder or for sexual disorders. Although state case laws have determined that specific questions about bipolar, psychotic, or sexual disorders are acceptable, professional organizations and court interpretations of the ADA recommend that the boards focus on current functional impairment instead of any history of diagnoses or treatment of illness. To support this position, there are no data showing that a broad question on a licensure application that asks about diagnosis or treatment for mental illness identifies current impairment.

The APA recommends that questions about the health of applicants should inquire only about the conditions that currently impair the applicant’s capacity to function as a licensee and are relevant to present practice. The APA further recommends that the boards use the following language in their application form:

“Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No)”

Interpretation and definition of “psychiatric conditions” and “impairment”

In 2011, the Federation of State Medical Boards (FSMB) adopted policy on physician impairment to provide guidance to boards for including physician health programs (PHPs) in their efforts to protect the public. The policy represented a vision for medical boards and PHPs to effectively assist impaired licensees as well as those with potentially impairing illness based on best practices.
The FSMB policy on physician impairment states:

“The diagnosis of an illness does not equate with impairment. Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. Illness, per se, does not constitute impairment. When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of potential impairment may be resolved while the diagnosis of illness may remain.”

AMA policy states:

“The AMA defines physician impairment as any physical, mental, or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program” (Policy H-95.955, “Physician Impairment”).

The FSMB defines impairment as:

“The inability of a licensee to practice medicine with reasonable skill and safety as result of:

a) mental disorder; or

b) physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or

c) substance-related disorders including abuse and dependency of drugs and alcohol as further defined.”

The Federation of State Physician Health Programs (FSPHP) created a public policy regarding “illness vs. impairment.” The following is an excerpt from this policy:

“...[S]ome regulatory agencies equate illness (i.e. addiction or depression) as synonymous with impairment. Physician illness and impairment exist on a continuum with illness typically predating impairment, often by many years. This is a critically important distinction. Illness is the existence of a disease. Impairment is a functional classification and implies the inability of the person affected by disease to perform specific activities.

“Most physicians who become ill are able to function effectively even during the earlier stages of their illness due to their training and dedication. For most, this is the time of referral to a state PHP. Even if illness progresses to cause impairment, treatment usually results in remission and restoration of function. PHPs are then in a position to monitor clinical stability and continuing progress in recovery…

“Medical professionals recognize it is always preferable to identify and treat illness early. There are many potential obstacles to an ill physician seeking care including: denial, aversion to the patient role, practice coverage, stigma, and fear of disciplinary action. Fear of disciplinary action and stigma are powerful disincentives to doctors referring their physician colleagues or themselves. When early referrals are not made, doctors afflicted by illness often remain without treatment until overt impairment is manifest in the workplace.”

There is some variability among the boards regarding how their applications request information about “psychiatric conditions (diagnosis/illness)” and “impairment.” Ideally, state and federal law should facilitate the effective interface between boards and PHPs in their efforts to support the rehabilitation of licensees with potentially impairing illness because it adds to public protection.
The FSMB encourages the boards, with input from their PHPs, to revisit their Medical Practice Acts routinely to ensure that they are kept updated in response to developments in the field.

**PHPs’ reporting requirements and patient confidentiality requirements**

The FSMB recommends that two separate PHP tracks be established for program participants:

- Track “A” is for voluntary participants who enter the PHP without the board’s mandate. These physicians should be afforded anonymity from the board as long as they do not pose a risk of harm to the public. Cases that pose a danger of harm to the public should be reported to the board with laws or regulations in place that allow that reporting.

- Track “B” physicians are mandated by the board to participate in a PHP. As such, their identities are known to the board.

In addition, the FSMB recommends that PHPs employ FSPHP Guidelines ([fsphp.org/sites/default/files/pdfs/2005_fsphp_guidelines-master_0.pdf](http://fsphp.org/sites/default/files/pdfs/2005_fsphp_guidelines-master_0.pdf)) in selecting the providers/facilities to provide treatment for physicians with addictive and/or psychiatric illness.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule related to mental and behavioral health ([hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html](http://hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html)) provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals’ trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information. At the same time, the Privacy Rule recognizes that circumstances arise where health information may need to be shared to ensure that the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others.

**Diagnosing depression for reimbursement can impact a physician’s permanent credentials**

Many physicians have expressed concern that a depression diagnosis could negatively impact their medical license. The consequences of reporting to a licensing board stable and easily treatable conditions such as anxiety or depression can range from a physician simply being required to submit a letter from their primary care provider that documents fitness to practice, to being asked to appear before state board examiners, or to being required to undergo (and pay for) an examination by a board-appointed physician. Other consequences can include having to provide extensive or ongoing medical records, enrolling in a PHP, paying for inpatient or intensive outpatient treatment that is possibly followed by long-term monitoring, or agreeing to practice restrictions.

**Physicians may be discouraged from seeking treatment for mental health conditions**

Even if physicians realize that they need help, many have reported substantial and persistent concern regarding the stigma, which inhibits both treatment and disclosure of mental health conditions on licensure applications. Those who disclose information about seeking mental health care have suffered delays in licensure and added scrutiny. The stigma of mental health is so pervasive that many physicians consider mental health issues to be a sign indicating that they are unable to cope with the rigor of the medical profession and that their ability to care for patients, therefore, is inferior to that of other physicians. Several surveys have shown that physicians are reluctant to enter into such disclosure because they fear this could expose them to examinations,
potentially inappropriate treatment and monitoring, or exclusion from employment opportunities, insurance coverage, or professional advancement.¹⁴

A 2016 survey of female physicians with a history of actual mental health diagnosis or treatment also provided insight into why this information is not routinely disclosed on licensure applications. The most common reasons listed were the beliefs that the condition did not pose any potential safety risk to patients (75 percent), was not relevant to clinical care (70 percent), and was not the business of the state medical board (63 percent).⁸ In addition, many of the survey respondents (75 percent) agreed or strongly agreed that medical board questions about whether a physician has ever had a mental health diagnosis or treatment impacts decisions about seeking treatment.⁸ The study also confirmed that more than two-thirds of physicians feel reluctant to seek out the same treatments they offer their patients for fear that they may be judged, deemed incompetent, or have their privacy and autonomy violated because of seeking help; these beliefs crossed all age and specialty categories.⁸

A similar study of licensure applicants showed that nearly 40 percent of physicians would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical license.⁶ Although providing inaccurate information on a medical license application may result in denial or revocation, acknowledging a history of mental health treatment triggers a more in-depth inquiry by the medical board.

The lack of distinction between diagnosis and impairment further stigmatizes physicians who seek care and impedes treatment.¹⁵ As a result, the traditional role of licensing boards can frustrate efforts to promote physician wellness.¹² Thus, physicians frequently seek treatment only when their psychological distress and suboptimal performance has gained the attention of insurance companies, police, and/or review boards.¹³

**FSMB WORKGROUP ON PHYSICIAN WELLNESS AND BURNOUT**

To address concerns about physician wellness, physician burnout, and suicide prevention, the FSMB established the Workgroup on Physician Wellness and Burnout on behalf of the state medical and osteopathic boards in 2016. In evaluating licensing and license renewal application questions that ask about health conditions, the workgroup is confronting the barriers physicians face in seeking treatment for symptoms of burnout related to the presence and phrasing of questions about mental health, substance use, and leave from practice.

The workgroup has been seeking to identify and highlight examples of effective and appropriate language in consideration of existing FSMB policies that draw an important distinction between physician illness and impairment.⁹ The workgroup also is researching this issue to determine whether it is necessary for the boards to include on licensing applications probing questions about a physician applicant’s mental health and whether the information these questions are designed to elicit in the interests of patient safety may be better obtained through means less likely to discourage the search for treatment among physician applicants.

The workgroup is in the process of finalizing its report and recommendations, and the FSMB will continue to update the public and the FSMB’s partner organizations, including the AMA, of its progress.
FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS

The FSPHP’s mission is to support PHPs in improving the health of medical professionals, thereby contributing to quality patient care. The FSPHP aims to:

- Achieve national and international recognition as a supporter of PHP programs;
- Promote early identification, treatment, documentation, and monitoring of ongoing recovery of physicians prior to the illness impacting the care rendered to patients; and
- Pursue consistent standards, language, and definitions among state physician health programs.

PHPs were originally developed to assist physicians suffering from alcohol or other addictions to receive treatment while being protected from losing their state medical licenses. In recent years, PHPs have also begun to intervene in other areas related to mental or physical health issues.

PHPs currently operate in 47 states and the District of Columbia; these programs function within the parameters of state regulation and legislation and provide many different levels of service to physicians in need. All state member PHPs must have compensated staff and/or a compensated medical director, and/or a voluntary committee chairperson/staff member, as well as the support of organized medicine in their state. Information about the full range of program structures and services offered by each state program is available at: fsphp.org/state-programs.

States have different reporting requirements related to impairment that have been agreed upon in their monitoring contracts with the state medical boards. Some of the programs offer a safe haven to encourage physicians to proactively seek and receive the health care services that they need, confidentially. For example, the North Carolina Physicians Health Program (NCPHP) can provide non-disciplinary and confidential assistance to ensure that the physician’s identity is protected, provided that the physician’s behavior has not negatively impacted patient care. The North Carolina Medical Board (NCMB) renewal question specifically states, “If you are an anonymous participant in the NCPHP and in compliance with your contract, you do not need to list any medical conditions related to that contract.” Thus a licensee who reaches out to the NCPHP for help with depression or other mental health concerns is generally not required to disclose these concerns to the board. Physicians are allowed to remain anonymous so long as the NCPHP can establish that they are safe to practice, are not an imminent danger to the public, or have not committed sexual boundary violations.

There are scenarios when an impaired physician is agreeable to referral to a PHP in which they may meet with safe haven or diversionary status, which does not require disclosure to a state medical board. Also, while a PHP will report a physician who meets the threshold of “public danger,” they may not re-disclose the specifics of the physician’s physical or mental health history. Due to the confidentiality requirements of the physician’s health records, more than likely the reported physician will sign consents and be required to release the necessary medical information to the licensing board directly as needed and not via the PHP.

AMA POLICIES

Policies related to questions on licensure applications

Policy H-295.858 (2), “Access to Confidential Health Services for Medical Students and Physicians,” states that “Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus
on current impairment by mental illness or addiction, and to accept “safe haven” non-reporting for
physicians seeking licensure or relicensure who are undergoing treatment for mental health or
addiction issues, to help ensure confidentiality of such treatment for the individual physician while
providing assurance of patient safety.”

Boards,” directs the AMA to “(1) encourage the Federation of State Medical Boards and its
constituent members to develop uniform definitions and nomenclature for use in licensing and
disciplinary proceedings to better facilitate the sharing of information, (2) seek clarification of the
application of the Americans with Disabilities Act to the actions of medical licensing and medical
specialty boards, and (3) encourage the American Board of Medical Specialties and the Federation
of State Medical Boards and their constituent members to advise physicians of the rationale behind
inquiries on mental illness, substance abuse or physical disabilities in materials used in the
licensure, reregistration, and certification processes when such questions are asked.”

Policies related to management of psychiatric disorders

Policy H-275.970, “Licensure Confidentiality,” directs the AMA “(1) to encourage specialty
boards, hospitals, and other organizations involved in credentialing, as well as state licensing
boards, to take all necessary steps to assure the confidentiality of information contained on
application forms for credentials; (2) to encourage boards to include in application forms only
requests for information that can reasonably be related to medical practice; (3) to encourage state
licensing boards to exclude from license application forms information that refers to
psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training;
(4) to encourage state medical societies and specialty societies to join with the AMA in efforts to
change statutes and regulations to provide needed confidentiality for information collected by
licensing boards; and (5) to encourage state licensing boards to require that, if an applicant has had
psychiatric treatment, the physician who has provided the treatment submit to the board an official
statement that the applicant’s current state of health does not interfere with his or her ability to
practice medicine.”

Policy H-95.955, “Physician Impairment,” states that: “(1) The AMA defines physician impairment
as any physical, mental or behavioral disorder that interferes with ability to engage safely in
professional activities and will address all such conditions in its Physician Health Program. (2) The
AMA encourages state medical society-sponsored physician health and assistance programs to take
appropriate steps to address the entire range of impairment problems that affect physicians, to
develop case finding mechanisms for all types of physician impairments, and to collect data on the
prevalence of conditions affecting physician health. (3) The AMA encourages additional research
in the area of physician impairment, particularly in the type and impact of external factors
adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the
health care delivery systems.”

DISCUSSION

There is growing concern that the presence and phrasing of questions related to current or past
impairment on licensing applications may be discouraging physicians from seeking appropriate
treatment because of fear of stigmatization, public disclosure, and the effect on one’s job due to
licensing or credentialing concerns. Resident physicians experience higher rates of depression than
the general public, and distressed physicians who do not seek treatment, especially for conditions
such as depression, anxiety, and burnout, may ultimately have an adverse effect on public safety
because they may be less likely to identify and treat similar conditions in their patients and more prone to medical errors in daily practice.3,17

The medical and osteopathic licensing boards recognize that in their responsibility to evaluate the fitness of potential licensees, a potential barrier may exist that prevents current and potential licensees from seeking help. Some state boards have taken steps to address these barriers. The Oregon Medical Board initiated a program to reduce physicians’ fear of reporting treatment on licensing or hospital credentialing applications. The board participates in the Health Professionals’ Services Program, which was established in July 2010 as a statewide confidential referral resource for rehabilitation and monitoring. It prioritizes the identification of impaired physicians and encourages licensees struggling with burnout, depression, or substance abuse to seek professional treatment.18 The Washington State Medical Board changed its initial medical license application in the mid-1990s to include a question that asks applicants if they have ever had a drug, alcohol, or mental health problem that is not already known to the PHP. This encouraged physicians to seek help anonymously. Currently, applicants are simply asked to disclose if they have any medical conditions that limit their ability to practice medicine.19

Some hospitals have responded to the focus on physician mental health by implementing programs to help residents and physicians improve their overall health.20 The AMA, American Osteopathic Association, and the state and specialty medical associations are also positioned to help alleviate the added stress physicians may experience as they interact with their respective licensing boards. The AMA has developed the following online resources focused on improving physician wellness, preventing burnout, and increasing resilience:

- Physician Wellness: Preventing Resident and Fellow Burnout (stepsforward.org/modules/physician-wellness)
- Preventing Physician Burnout (stepsforward.org/modules/physician-burnout)
- Improving Physician Resiliency (stepsforward.org/modules/improving-physician-resilience)

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education is committed to ensuring that physicians seek the care they need for burnout, anxiety, depression, and substance-related disorders without fear of punitive treatment or licensure and career restrictions. The Council therefore recommends that the following recommendations be adopted in lieu of Resolution 301-A-17, Resolve 3, and the remainder of the report be filed.

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

The AMA (5) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is currently suffering from any condition that impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine. (Modify Current HOD Policy)
2. That our AMA encourage those state medical boards that wish to retain questions about the
health of applicants on medical licensing applications to use the language recommended by the
American Psychiatric Association that reads, “Are you currently suffering from any condition
that impairs your judgment or that would otherwise adversely affect your ability to practice
medicine in a competent, ethical and professional manner? (Yes/No).” (Directive to Take
Action)

Fiscal Note: $1,000
REFERENCES


Whereas, It is not uncommon for medical students and resident physicians to have occupational hazardous/biohazard exposure; and

Whereas, There is no standardized education of medical students, resident physicians, and teaching attending physicians regarding the effects of occupational hazardous/biohazard exposure and the deleterious effects on individuals and/or their unborn child, beyond blood-borne infections; and

Whereas, There has been an increase in the number of female trainees in medicine, who may desire to maintain their medical history in privacy; therefore be it

RESOLVED, That our American Medical Association call for the mandatory education of students, residents, physicians and surgeons on the deleterious effects of exposure to hazardous materials (Directive to Take Action); and be it further

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

RESOLVED, That our AMA support and encourage the specific option for students or trainees to be able to excuse themselves from exposure to Methylmethacrylate if they are or think they may be pregnant without negatively impacting their standing in their school or training programs (New HOD Policy); and be it further

RESOLVED, That our AMA support and encourage constant updating of the protection of medical trainees, physicians and surgeons from exposure to hazardous materials during the course of their medical school training and practice, using standards published by the Occupational Safety and Health Administration; the National Institute for Occupational Safety and Health and other Centers for Disease Control and Prevention agencies; the College of American Pathologists; and the American College of Radiology, as well as other relevant resources available for health workers. (New HOD Policy)

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

Received: 12/04/17
Whereas, The United States faces an impending shortage of primary care or family medicine physicians, particularly in rural areas; and

Whereas, For-profit medical schools are increasing in number; and

Whereas, Graduates from these colleges typically face twice the debt of graduates from not-for-profit or public medical schools; and

Whereas, For-profit medical schools are generally less financially stable than their not-for-profit counterparts; therefore be it

RESOLVED, That our American Medical Association study issues related to medical education programs offered at for-profit medical schools and report back at the 2019 Annual Meeting.

(Directive to Take Action)

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

Received: 03/06/18
Whereas, For the past fifteen years, orthopedic surgery has been unique by having nearly all of their fellowships start on August 1st; and

Whereas, This practice is slowly expanding with Surgical Critical Care, Thoracic, Transplant, Colorectal and Pediatric Surgery Fellowships having transitioned to the August 1st start date in 2016; and

Whereas, The benefits of a later start date are thought to be related to alleviating some of the logistical challenges associated with completing residency on June 30th and beginning fellowship July 1; and

Whereas, Often times, fellows are required to move to different cities or hospitals in this short timeframe as many of these fellowships may begin orientation before July 1; and

Whereas, Residency graduates need to prepare for the many specialty board exams that occur in the month of July; and

Whereas, Moving the fellowship start date ensures that trained fellows are in the hospital during July, when new residents are just beginning their training and can be transitioned by their experienced fellows; and

Whereas, Resident health insurance, disability insurance, salary and malpractice benefits terminate at the conclusion of residency, leaving the potential for a gap period during which the future fellow could be without benefits or salary, placing a unique set of challenges on the resident which may be further complicated by provisions requiring individuals to maintain health insurance, be compliant with visa/immigration requirements or be involved in litigation; and

Whereas, Adoption of transitioning to the August 1st start date was generally supported by both residents and surgery program directors, who felt that residents can purchase COBRA health insurance and that the gap in income was an acceptable tradeoff for the other perceived benefits; and

Whereas, No retrospective reviews have been performed to characterize the degree to which changing the fellowship start date alleviated or worsened the transition and fellows had mixed preferences on the ideal start date of their fellowship in a survey of the Council on Pediatric Subspecialties; therefore be it
RESOLVED, That our American Medical Association survey physicians who have experienced a fellowship start date of August 1st to further evaluate the benefits and drawbacks from this transition. (Directive to Take Action)

Fiscal Note: Estimated cost to implement the resolution is $34,000.

Received: 03/23/18

References:
1. Fellowship Start Date Action Team; http://www.pedsubs.org/pdf/Slides%20May%202014%20Meeting.pdf

RELEVANT AMA POLICY

H-310.912 Residents and Fellows' Bill of Rights
Whereas, Few physicians have had formal training regarding the specific needs of patients with intellectual and developmental disabilities (IDD) or may not possess the comfort level required to treat people with IDD and only 25% of medical schools include content regarding people with such disabilities in their curricula; and

Whereas, All medical school graduates should, by demonstration of necessary knowledge, skills, and attitudes, be comfortable and competent in assessing and participating in the comprehensive continuing management of patients with disability due to disorders of the nervous, musculoskeletal, or closely related systems; and

Whereas, AMA Policy H-90.968, “Medical Care of Persons with Developmental Disabilities,” articulates the importance of educating medical students, medical residents, and physicians about the medical care of and health disparities experienced by patients with developmental disabilities; and

Whereas, Persons with intellectual and developmental disabilities are less likely to receive adequate medical care than the general population despite their increased burden of chronic health problems and shortened life expectancy; and

Whereas, The federal government defines “medically underserved populations” (MUP) according to a formula that weighs a population’s lack of primary care providers, its experience with poverty and infant mortality, and its percentage of people over age 65 and then applies that result to a population within a defined geographic area; and

Whereas, Persons with IDD are not limited to particular geographic areas; and

---

2 Educational Goals and Objectives in Physical Medicine and Rehabilitation for the Medical School Graduate: a position statement approved by the American Academy of Physical Medicine and Rehabilitation Board of Governors August 2012.
5 Health Resources & Services Administration, Medically Underserved Areas and Populations (MUA/Ps) shortage designation, (https://bhw.hrsa.gov/shortage-designation/muap)
Whereas, Our AMA6, and American College of Physicians7 have previously articulated the need for persons with intellectual and developmental disabilities to have MUP designation; therefore be it

RESOLVED, That our American Medical Association advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools and graduate medical education programs to include IDD-related competencies and objectives in their curricula. (New HOD Policy)

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

Received: 04/17/18

RELEVANT AMA POLICY

Medical Care of Persons with Developmental Disabilities H-90,968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities. 2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals. 3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them. 4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities. 5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community. 6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities. 7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities. 8. Our AMA encourages the Accreditation Council for Continuing Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities. 9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.

Early Intervention for Individuals with Developmental Delay H-90,969
(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.  CCB/CLRDP Rep. 3, A-14 Reaffirmed: Res. 306, A-14 Reaffirmed: Res. 315, A-17

Abbreviations:

- AMA: American Medical Association
- CCB: Council on Continuing Medical Education
- CLRPD: Commission on Osteopathic College Accreditation
- HOD: House of Delegates

6 American Medical Association CMS Report 3-I-11: Designation of the Intellectually Disabled as a Medically Underserved Population (resolution 805-I-10)
Whereas, Thirty-one states have a set time limit of seven years to complete the USMLE licensing sequence, 29 states allow 10 years specifically for MD/PhD student, 37 states allow 10 years for DO/PhD students to complete the COMLEX sequence, and at least 20 states have different time limits for USMLE and COMLEX sequences;¹ and

Whereas, Seven states have no time limit to complete the USMLE sequence, and at least 22 states have no time limit to complete the COMLEX sequence;¹ and

Whereas, Of the state medical and osteopathic boards which have a time limit, 10 years with potential waivers is the greatest of the time limits;¹ and

Whereas, A recent study by Holmes et al. (2017) measures the average time to complete social science and humanities MD/PhDs to be 9 years;² and

Whereas, All state licensing jurisdiction require 1 year of graduate medical education before licensure for US medical graduates, 12 states require 2 years and 25 states require 3 years of accredited graduate medical education for foreign medical graduates;³ ⁴ and

Whereas, Current AMA Abolish Discrimination in Licensure of IMGs H-255.966 calls for the elimination of disparities in graduate training requirements for licensure; and

Whereas, Opportunities such as moonlighting can depend on having a full medical license;⁵ and

Whereas, The lack of a nation-wide policy leads to situations where students with identical training timelines have differing ability to obtain a license, simply depending on the state’s policy where they receive training; therefore be it

¹FSMB. State-Specific Requirements for Initial Medical Licensure. Retrieved from https://www.fsmb.org/licensure/usmle-step-3/state_specific
RESOLVED, That our American Medical Association amend Policy H-275.978, "Medical Licensure," by addition to read as follows:

The AMA:

(1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;

(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;

(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;

(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;

(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);

(7) urges licensing boards to maintain strict confidentiality of reported information;

(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;

(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;

(10) urges all physicians to participate in continuing medical education as a professional obligation;

(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;

(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;

(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;

(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;

(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of
examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and

(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.

(23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX. (Modify Current HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY
Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934
Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards that are reported for all licensed physicians. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean’s Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.


See also: Abolish Discrimination in Licensure of IMGs H-255.966
Whereas, Research has identified sex-based differences in etiology, prevention measures, presentation, and response to treatment for health conditions in all organ systems; and

Whereas, The Institute of Medicine in its report, *Women’s Health Research: Progress, Pitfalls, and Progress*, published in 2010, noted that this research was not being consistently applied to clinical practice; and

Whereas, Surveys of medical students note inconsistent inclusion of teaching of sex-based differences in medical school curricula; and

Whereas, Our AMA stated in CSAPH Report 6, A-16, “An Expanded Definition of Women’s Health” that “understanding sex differences that impact health and disease will lead to better care for both men and women” and “recommend(ed) that the AMA adopt policy acknowledging the role that sex and gender play in health;” and

Whereas, The Liaison Committee on Medical Education, in their standards for accreditation (effective 2017), in paragraph 7.2, notes that medical education should prepare students to recognize determinants of health; and

Whereas, Sex and gender are significant determinants of health which extend beyond only the scope of gender bias; therefore be it

RESOLVED, That our American Medical Association work collaboratively with the Liaison Committee on Medical Education for the inclusion of sex-based differences within the mandated curricular content for medical school accreditation. (Directive to Take Action)

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

Received: 04/30/18
Whereas, Existing AMA policies and recent publications have called attention to the need for topics of healthcare finance and medical economics to be featured in medical education curricula in order to equip future physicians with the knowledge to practice medicine in today's ever-changing healthcare environment;¹,² and

Whereas, There has been little to no study on whether schools have been incorporating these topics and/or how effective these changes have been; and

Whereas, Recent empiric and anecdotal evidence indicates that physicians and residents still rate their knowledge of healthcare finance and medical economics as fair or low,³,⁴,⁵ and it is widely acknowledged that new physicians are not well-prepared to understand topics such as physician reimbursement, compensation and practice models,⁶,⁷ and

Whereas, The Liaison Committee on Medical Education outlines that “medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine,” but does not directly advocate for the inclusion of topics like healthcare finance or medical economics into medical school curricula;⁷ therefore be it

RESOLVED, That our American Medical Association study the extent to which medical schools and residency programs are teaching topics of healthcare finance and medical economics (Directive to Take Action); and be it further

RESOLVED, That our AMA make a formal suggestion to the Liaison Committee on Medical Education encouraging the addition of a new Element, 7.10, under Standard 7, “Curricular Content,” that would specifically address the role of healthcare finance and medical economics in undergraduate medical education. (Directive to Take Action)

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

Received: 04/30/18
RELEVANT AMA POLICY

Health Care Economics Education D-295.321
Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician’s professional life, starting in undergraduate medical education, graduate medical education and continuing medical education.
Citation: (Res. 320, A-09; Reaffirmation I-15)

Future Directions for Socioeconomic Education H-295.924
The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum;
(2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and
(3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum.
Citation: CME Rep. 1-I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Reaffirmation A-12; Reaffirmation I-15; Reaffirmed in lieu of: Res. 307, A-17;

Socioeconomic Education for Medical Students H-295.977
1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula.
2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9.

References:
8 Liaison Committee on Medical Education. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree. April 2016.
Resolution: 308
(A-18)

Introduced by: International Medical Graduates Section
Subject: Foreign Trained IMGs Obtaining a U.S. License Without U.S. Residency
Referred to: Reference Committee C
(Sherri Baker, MD, Chair)

Whereas, There is a predicted shortage of 40,800-104,900 physicians in the U.S. by 2025;¹ and
Whereas, There are many qualified International Medical Graduates (IMGs) waiting for a residency position²; and
Whereas, U.S. medical schools and the Accreditation Council of Graduate Medical Education (ACGME) are moving towards competency-based criteria and not necessarily time-based criteria for graduation³; and
Whereas, Many overseas residency programs are equally as rigorous as residency programs in the U.S.; and
Whereas, Many well trained and experienced IMGs could meet the competency-based criteria required for graduation from the residency programs; and
Whereas, There is precedent where several physicians who were trained abroad entered medical practice in the U.S., or even served on U.S. medical school faculties, without being required to undergo any additional residency training; therefore be it
RESOLVED, That our American Medical Association accept it as a policy that International Medical Graduates who have completed residency programs in their own countries, have passed the USMLE I, II, and III should be eligible for a license to practice medicine without additional residency training in the U.S. (Directive to Take Action)

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

Received: 05/01/18

³ACGME Common Program Requirements for Graduate Medical Education, http://www.acgme.org
RELEVANT AMA POLICY

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317

1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.

2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.

3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents’ compensation and lifetime earnings.

Citation: CME Rep. 3, A-14; Appended: CME Rep. 04, A-16;

Mechanisms to Measure Physician Competency H-275.936

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.


See also:
AMA Principles on International Medical Graduates H-255.988
Recommendations for Future Directions for Medical Education H-295.995
Whereas, There is a predicted shortage of 40,800-104,900 physicians in the U.S. by 2025;¹ and
Whereas, There are many qualified International Medical Graduates (IMGs) waiting for a residency position;² and
Whereas, U.S. medical schools and the Accreditation Council of Graduate Medical Education (ACGME) are moving towards competency-based criteria and not necessarily time-based criteria for graduation;³ and
Whereas, Many overseas residency programs are equally as rigorous as residency programs in the U.S.; and
Whereas, Many well trained and experienced IMGs could meet the competency-based criteria required for graduation from the residency programs; and
Whereas, There is precedent where several physicians who were trained abroad entered medical practice in the U.S., or even served on U.S. medical school faculties, without being required to undergo any additional residency training; therefore be it
RESOLVED, That our American Medical Association work with other stakeholders including the Accreditation Council of Graduate Medical Education, Association of American Medical Colleges and the American Board of Medical Specialties, to advocate that International Medical Graduates who have completed residency programs in their own countries should be eligible to take the specialties exam without being required to complete additional residency training in the U.S. (Directive to Take Action)

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

Received: 05/01/18

³ACGME Program Requirements for Graduate Medical Education, http://www.acgme.org
RELEVANT AMA POLICY

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317
1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents’ compensation and lifetime earnings.
Citation: CME Rep. 3, A-14; Appended: CME Rep. 04, A-16;

Mechanisms to Measure Physician Competency H-275.936
Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.

See also:
AMA Principles on International Medical Graduates H-255.988
Recommendations for Future Directions for Medical Education H-295.995
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-18)

Introduced by: International Medical Graduates Section

Subject: U.S. Institutions with Restricted Medical Licensure

Referred to: Reference Committee C
(Sherri Baker, MD, Chair)

Whereas, IMGs in the past were permitted to work in academic institutions in some states, either for their specific skills or for a need due to scarce interest of American physicians in certain specialties or geographical areas; and

Whereas, These physicians were allowed to work with an institutional or faculty temporary license granted by their local State Medical Board without having completed the USMLE examination, having ECFMG certification and without being American Board certified or eligible in their specialty; and

Whereas, These physicians completed medical school and specialty training abroad were often excellent candidates with strong curricula and their titles were recognized equivalent to the ones received in the U.S. by the receiving academic institution to allow them to work; and

Whereas, In recent years, these physicians faced the problem that many academic and non-academic institutions created rules to have only American Board Certified physicians among their faculty/staff and were unwilling to grant institutional licenses any longer; and

Whereas, This issue creates a dramatic situation for these physicians who have practiced in the U.S. for many years, bringing unique skills and much needed service for the American people and medical system; and

Whereas, In these academic institutions, these physicians have actively trained many medical students and specialists and have started new programs to allow young American physicians to become eligible to work without restrictions while their IMG professors are not; and

Whereas, These IMGs were admitted to work in the U.S. to fill a void and a need which may affect them due to more restrictive changes which are not considering such unique situations. These physicians are faced with losing their jobs without the ability to practice anywhere in the U.S.; therefore be it

RESOLVED, That our American Medical Association work with the Organized Medical Staff Section and other stakeholders to prevent hospitals from restricting the practice of medicine only to American board certified physicians (Directive to Take Action); and be it further

RESOLVED, That the AMA work with the Federation of State Medical Boards and other stakeholders to develop a process to grant unrestricted licensure for those who have practiced at least 10 years in U.S. academic institutions under institutional or faculty temporary licensure. (Directive to Take Action)
Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/18

RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15

See also: Maintenance of Certification H-275.924
Whereas, Education for trainees about opioids varies significantly between residencies and specialties; and

Whereas, Nearly half of all opioid-related deaths involve prescription opioids¹; and

Whereas, 64,000 people died from overdoses² in 2016, costing over $500 billion,³ and the United States Government officially declared the opioid crisis a public health emergency in 2017; therefore be it

RESOLVED, That our American Medical Association work in conjunction with the Accreditation Council for Graduate Medical Education to establish opioid education guidelines for physicians in training. (Directive to Take Action)

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

Received: 05/02/18

Footnotes:
² Provisional counts of overdose deaths for the USA. Centers for Disease Control and Prevention
³ The council of economic advisors. The underestimated cost of the opioid crisis. 2017
Whereas, In 2015, suicide was the tenth leading cause of death in the United States and is the second leading cause of death of people aged 15-24; and

Whereas, In 2015, the State of Michigan had a suicide rate of 14.2 per 100,000 people; and

Whereas, In 2012, the Surgeon General and Institute of Medicine called for health care systems around the nation to aid in reducing the number of yearly suicides stating, "clinical preventive services, including suicide assessment and preventive screening by primary care and other health care providers, are crucial to assessing suicide risk and connecting individuals at risk for suicide to available clinical services and other sources of care;" and

Whereas, More potential years of life are lost to suicide than to any other single cause except heart disease and cancer; and

Whereas, In 2013, the cost of one suicide in the United States was assessed to be $1,329,553; and

Whereas, Sixty-four percent of people who attempt suicide have visited a physician in the month prior to their suicide attempt, and 38 percent of those who attempt suicide visit a physician in the week before; and

Whereas, Community-based suicide prevention programs have been shown to be a cost-effective way to lower costs to the health care system from averted suicide attempts and decrease the number of suicides in communities with prevention programs; and

Whereas, The Henry Ford Health System started a ZEROSuicide initiative in 2001 to cut the suicide rate among its patients, and demonstrated an 80 percent reduction in suicide among the Henry Ford Medical Group HMO membership that has been maintained for a decade since the implementation of this program; and

Whereas, Centerstone of Tennessee saw a reduction in the rate of suicides from 3.1 to 1.7 per 10,000 two years after initiating the ZEROSuicide initiative within their health system; and

Whereas, The Texas Department of Health and Human Services implemented the ZEROSuicide initiative statewide beginning in 2014; therefore be it
RESOLVED, That our American Medical Association engage with the Liaison Committee on Medical Education to encourage the inclusion of formalized suicide awareness training, using an evidence-based multidisciplinary approach, in the curriculum of all accredited medical schools.

(Directive to Take Action)

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

Received: 05/02/18

RELEVANT AMA POLICY

Teen and Young Adult Suicide in the United States H-60.937
Our AMA recognizes teen and young-adult suicide as a serious health concern in the US.
Citation: Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16;

Senior Suicide H-25.992
It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.
Citation: (Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

2 Ibid
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-18)

Introduced by: Michigan

Subject: Financial Literacy for Medical Students and Residents

Referred to: Reference Committee C
(Sherri Baker, MD, Chair)

Whereas, Approximately 75 percent of all medical students have some form of educational debt, and the current median debt load for a US medical graduate is $192,000; however, this rises each year1,2; and

Whereas, The physician shortage in particular specialties can be attributed to the large amount of student debt, as it has been found to discourage students from going into primary care specialties and/or working in underserved areas3,4; and

Whereas, On an individual level, financial instability and high student debt can create stressful situations for medical students, may delay other life milestones (such as homeownership, having children, or saving for retirement), and can take away from patient-centered care and relationships with colleagues4,5,6,7; and

Whereas, Only less than five percent of students feel very knowledgeable about loan repayment and/or personal finance, but having financial and debt literacy can allow people to make better informed decisions with banking, credit cards, saving/investing, and budgeting8,9; and

Whereas, While some programs offer MD/MBA programs and finance-related electives, many medical schools offer minimal exposure to education on business, management, financial literacy, and entrepreneurship in medicine10,11,12; and

Whereas, Medical residents face an enormous amount of financial stress, which can contribute to resident burnout and result in difficulty obtaining new loans or receiving financial guidance\textsuperscript{13,14}, and

Whereas, Thirty-four percent of residents are concerned with paying off their medical school debt, and 62 percent of residents feel behind in their retirement savings\textsuperscript{15}; and

Whereas, The American Medical Association has previously resolved to support the education of students in administrative and leadership aspects of medical management\textsuperscript{16}; therefore be it

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

Management and Leadership for Physicians D-295.316
1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs between medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving financial literacy and leading interprofessional team care, in the spirit of the AMA’s Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and financial literacy capabilities.

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

Received: 05/02/18

RELEVANT AMA POLICY

Management and Leadership for Physicians D-295.316
1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs between medical schools and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving financial literacy and leading interprofessional team care, in the spirit of the AMA’s Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership capabilities.

Citation: Sub. Res. 918, I-14; Appended: Res. 306, I-16; Reaffirmed in lieu of: Res. 307, A-17;

\textsuperscript{13} McNeeley MF., et al. The Emotional Wellness of Radiology Trainees. Academic Radiology Volume 20, Issue 5, 647 - 655


Whereas, Opioid use has been declared a national epidemic by the Centers for Disease Control; and

Whereas, The American Board of Addiction Medicine (ABAM) provided Addiction Medicine board certification from 2009 to 2015; and

Whereas, When Addiction Medicine (ADM) was officially recognized as a new subspecialty by the American Board of Medical Specialties (ABMS) on March 14, 2016, ADM board certification moved to ABMS oversight; and

Whereas, ABMS is mandating current ABMS certification in any ABMS-recognized Member Board specialty as a requirement to enroll in a transitional maintenance of certification program and to qualify for the ABMS Addiction Medicine board certification examination; and

Whereas, Many ABAM-board certified Addiction Medicine specialists have not maintained board certification in an ABMS-recognized Member Board specialty; and

Whereas, These duly certified ADM specialists may be unable to obtain hospital privileges and/or third-party patient panel privileges as they are not considered to be board certified by the ABMS, thus potentially limiting access to this crucial resource; therefore be it

RESOLVED, That our American Medical Association work with the American Board of Addiction Medicine (ABAM) and American Board of Medical Specialties (ABMS) to accept ABAM board certification as equivalent to any other ABMS-recognized Member Board specialty as a requirement to enroll in the transitional maintenance of certification program and to qualify for the ABMS Addiction Medicine board certification examination. (Directive to Take Action)

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

Received: 05/02/18
RELEVANT AMA POLICY

Recognition of Those Who Practice Addiction Medicine H-300.962
1. It is the policy of the AMA to: (a) encourage all physicians, particularly those in primary care fields, to undertake education in treatment of substance abuse; (b) direct its representatives to appropriate Residency Review Committees (RRCs) to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance abuse. Those RRCs that already require such instruction should consider greater emphasis for this subject. (c) encourage treatment of substance abuse as a subject for continuing medical education; and (d) affirm that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse, and for utilization review, and for other evaluation of such treatment, and should be entitled to compensation.
2. Our AMA commends the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards.
3. Our AMA encourages the ABPM to offer the first ABMS-approved certification examination in addiction medicine expeditiously in order to improve access to care to treat addiction.

Medical Specialty Board Certification Standards H-275.926
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15
Whereas, The current Association of American Medical Colleges’ guidelines emphasize
promotion of cultural competence in medical education; however, cultural competence fails to
account for the intricacies of cultural humility which posits that one cannot ever fully be
competent in another’s culture\(^1,2\); and

Whereas, Cultural humility is a lifelong process of self-reflection and self-critique whereby the
individual not only learns about another’s culture, but one starts with an examination of his or
her own beliefs and cultural identities\(^3\); and

Whereas, Learning cultural humility is vital for physicians because poor health communication
between a physician and patient of a different cultural background can lead to poor health
outcomes\(^4\); and

Whereas, Cultural competence is primarily taught in a didactic setting in medical schools;
however, studies have found that didactic instruction alone was not sufficient in achieving
cultural proficiency, yet a combination of didactic instruction and cross-cultural activities proved
more effective in improving comprehensive cultural competence\(^5,6\); and

Whereas, Peer-facilitated intergroup dialogue is a facilitated group experience that may occur
once or may be sustained over time and is designed to give individuals and groups a safe and
structured opportunity to explore attitudes about polarizing societal issues\(^7\); and

Whereas, Peer-facilitated and structured interactions of intergroup dialogue are important for
creating engagement across differences which would lend to better communication between
physicians and patients of diverse backgrounds\(^8\); and

Whereas, Studies have shown clear evidence of dialogue leading to increased intergroup
understanding and attitude change\(^9\); and

Whereas, A few medical schools such as Georgetown and New York University have already
adopted intergroup dialogue into their curriculum\(^10,11\); and

Whereas, The American Medical Association has previously resolved to support efforts
designed to integrate training in cultural competence across the undergraduate medical school
curriculum\(^12\); therefore be it
RESOLVED, That our American Medical Association work with the AMA Council on Medical Education and Academic Physician Section to encourage the Accreditation Council for Osteopathic Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to include peer-facilitated intergroup dialogue in medical education programs nationwide. (Directive to Take Action)

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

Received: 05/02/18

RELEVANT AMA POLICY

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students’ appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students’ cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

Citation: (CME Rep. 11, A-06; Reaffirmation A-11; Modified in lieu of Res. 908, I-14; Reaffirmed in lieu of Res. 306, A-15)

See also: Enhancing the Cultural Competence of Physicians H-295.897

1 American Academy of Medical Colleges. Cultural Competence Education for Medical Students. 2005.
Whereas, A mandatory component of American Board of Medical Specialties Maintenance of Certification (ABMS MOC®) Program is the “Part 4 Improvement in Medical Practice”; and

Whereas, Non-grandfathered physicians are required to participate in these proprietary Part 4 quality improvement projects upon threat of losing board certification, and subsequent hospital privileges and insurance plan participation; and

Whereas, Innovative and relevant “quality improvement” projects take place daily in physician offices as part of our commitment to excellence, outside of ABMS MOC® mandates; and

Whereas, Quality improvement is not the proprietary product of ABMS MOC®; and

Whereas, Overwhelming physician opinion is that these proprietary ABMS MOC® projects are duplicative busywork with little application to patient care; and

Whereas, ABMS MOC® diverts time and resources from relevant medical research and quality improvement; and

Whereas, There is no data to suggest any difference in patient health outcomes from ABMS MOC® quality improvement projects versus quality improvement projects that do not grant ABMS MOC® credit; and

Whereas, Published data from these quality improvement projects are used by ABMS as proof, not of innovative physician efforts to improve patient outcomes, but as justification for the proprietary ABMS MOC® product to insurers, hospitals, and the Internal Revenue Service; and

Whereas, Physicians find themselves unwilling research subjects and their patient data used in the promotion of a proprietary educational product; therefore be it

RESOLVED, That our American Medical Association call for an end to the mandatory American Board of Medical Specialties “Part 4 Improvement in Medical Practice” maintenance of certification requirement. (Directive to Take Action)

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

Received: 05/02/18

The topic of this resolution is currently under study by the Council on Medical Education.

See AMA Policies: Maintenance of Certification H-275.924; Maintenance of Certification and Osteopathic Continuous Certification D-275.954
Reference Committee D

BOT Report(s)
11 Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States
27 Policy and Economic Support for Early Child Care
28 Mandatory Public Health Reporting of Law-Enforcement-Related Injuries and Deaths

CSAPH Report(s)
01 CSAPH Sunset Review of 2008 House of Delegates Policies
04 The Physician's Role in Firearm Safety
05 Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking

Resolution(s)
401 Danger from Bright Vehicle Headlights
402 Schools as Gun-Free Zones
403 School Safety and Mental Health
404 Emphasizing the Human Papillomavirus Vaccines as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic
405 Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data
406 Support for Public Health Violence Prevention Programs
407 Support for Research of Boxes for Babies' Sleeping Environment
408 Ending Money Bail to Decrease Burden on Lower Income Communities
409 Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities
410 Opposition to Measures that Criminalize Homelessness
411 Reporting Child Abuse in Military Families
412 Reducing the Use of Restrictive Housing in Prisoners with Mental Illness
413 Improving Safety and Health Code Compliance in School Facilities
414 Sex Education Materials for Students with Limited English Proficiency
415 Reducing Gun Violence in America
416 Medical Respite Care for Homeless Adults
417 Reducing Disparities in Obstetric Outcomes, Maternal Morbidity, and Prenatal Care
418 A Guide for Best Health Practices for Seniors Living in Retirement Communities
419 Violence Prevention
420 Mandatory Influenza Vaccination Policies for Healthcare Workers
421 Product Date Labels
422 School Drinking Water Quality Testing, Monitoring, and Maintenance
423 Grill Brush Warning
424 Rape and Sexual Abuse on College Campuses
425 Hospital Food Labeling
INTRODUCTION

Resolution 208-A-17, “Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States,” introduced by the Medical Student Section (MSS) and referred by the House of Delegates (HOD) asked that our AMA amend Policy H-160.903, “Eradicating Homelessness,” to read as follows:

H-160.903 Eradicating Homelessness
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.

Policy H-160.903 originated as Resolution 401-A-15, which also was introduced by the MSS. As proposed, it asked that our AMA (1) support improving the health outcomes and decreasing health care costs of treating the chronically homeless through Housing First approaches; and (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness. The Housing First language was removed by the reference committee due to concerns regarding the “program’s effectiveness among a subset of the homeless who are dually-diagnosed with mental health or substance abuse issues.” The intent of the reference committee was to extend support to many approaches to combat homelessness, including but not limited to Housing First. The House of Delegates concurred with this approach.

CURRENT AMA POLICY

As noted above, existing Policy H-160.903 supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services. Additionally, Policy H-160.978 describes the components that should be included in public policy initiatives addressing the homeless who have mental health problems.
These include access to care, clinical concerns, program development, and educational, housing, and research needs.

BACKGROUND

Based on the 2017 Annual Homeless Assessment Report to Congress, more than 553,000 people experience homelessness (defined as a person who lacks a fixed, regular, and adequate nighttime residence) in the United States on a single night. Most (65 percent) were staying in emergency shelters or transitional housing programs, with the remaining (35 percent) staying in unsheltered locations. Substance use disorders (SUD) and mental health problems are much more prevalent among people who are homeless than in the general population. According to the Office of National Drug Control Policy, approximately 30 percent of people experiencing chronic homelessness have a serious mental illness, and around two-thirds have a primary substance use disorder or other chronic health condition. Lack of stable housing leaves them vulnerable to substance use and/or relapse, exacerbation of mental health problems, and a return to homelessness. Resolution 208-A-17 is specific to chronically-homeless individuals, which refers to those who are either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more; or (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years.

DISCUSSION

There are two common approaches to addressing homelessness in the United States, the linear approach and Housing First. The linear approach assumes that individuals who are homeless need to graduate from a sequence of programs designed to address underlying conditions before they will become “housing ready.” This approach also emphasizes abstinence from substance use as an explicit goal. Housing First uses a harm reduction approach by connecting individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Case management services are offered to residents, but it is a personal choice to address SUDs or mental health problems.

Federal Strategic Plan to End Homelessness

The first comprehensive federal strategic plan to prevent and end homelessness, “Opening Doors,” was presented to Congress in June 2010. The strategic plan was updated in 2012 and 2015 and it is anticipated that it will be updated again in 2018. Since the adoption of the federal strategic plan, the federal government has emphasized Housing First, not only as a model plan, but as a community-wide approach and guiding principle. Related goals include ensuring widespread adoption of a Housing First approach, thereby lowering barriers to housing entry.

Approaches to End Homelessness: The Evidence

Evidence exists to support the effectiveness of the Housing First and linear models; each model exhibits different strengths and weaknesses. Housing First interventions are effective in improving housing stability and quality of life among individuals who are homeless. Studies have shown that Housing First programs significantly increase the time that people are stably housed. However, evidence is mixed on the effectiveness of Housing First in improving outcomes related to SUDs suggesting that individuals experiencing SUDs may need additional support and services to reduce substance use.
The linear model is more effective in achieving abstinence than non-abstinence dependent housing. Studied for many years as part of the linear approach to homelessness, SUD treatment programs have demonstrated moderate effectiveness, but significant problems exist with retention. Even when individuals in linear service models achieve abstinence, they are vulnerable to reoccurrence of homelessness if they are not able to find permanent housing and to relapse of their SUD.

CONCLUSION

There are two common approaches to addressing homelessness in the United States. The federal government has adopted the Housing First approach as a part of its national strategic plan on addressing homelessness. Evidence supports the effectiveness of Housing First in improving housing stability and quality of life in individuals who are homeless. The linear approach is more effective in achieving abstinence from substance use among those who were homeless, but such individuals remain vulnerable to reoccurrence of homelessness and relapse in their SUD. Different individuals may benefit from one approach or the other. Current AMA policy is rooted in the support of clinically proven, high quality, and cost effective approaches to reducing homelessness. Adaptive strategies based on regional variations, community characteristics, and state and local resources are necessary to address this societal problem on a long-term basis.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 208-A-17 and the remainder of the report be filed:

That Policy H-160.903, “Eradicating Homelessness,” be amended to reads as follows:

H-160.903 Eradicating Homelessness

Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis; and (4) supports the appropriate organizations in recognizing the need for an effective, evidence-based developing an effective national plan to eradicate homelessness.

Fiscal Note: less than $500
REFERENCES

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Resolution 416-A-17 was referred. Introduced by the New England Delegation and the Minority Affairs Section, Resolution 416-A-17 asked that our American Medical Association (AMA) advocate for: (1) improved social and economic support for paid family leave to care for newborns, infants, and young children; and (2) federal tax incentives to support early child care and unpaid child care by extended family members.

BACKGROUND

Increases in paid parental leave were associated with decreases in perinatal, neonatal, post-neonatal, infant, and child mortality in a sample of 18 Organization for Economic Co-operation and Development countries.1

Unpaid maternal leave provided through the Family and Medical Leave Act of 1993 (FMLA) in the US was associated with decreases in neonatal, post-neonatal, and infant mortality, but only among women who were married and had graduated from college, suggesting that women of lower socioeconomic position were unable to benefit from unpaid leave.

Although the FMLA requires larger employers to provide unpaid job-protected time off, there is no current federal law that requires employers to provide paid time off for the birth or care of children. About 38 percent of employers offer paid parental leave for employees who are new parents.2 Paid parental leave is distinct from other paid-leave programs such as short-term disability, sick days, and government-funded disability or insurance payments.3 Smaller employers in particular are less likely to provide meaningful paid time off beyond generic vacation or sick time. Further, much of the time off that is provided as it relates to children is oriented toward the period surrounding the birth of a child and typically does not extend to infants and young children as contemplated by Resolution 416-A-17. What success there has been in providing paid parental leave has been primarily at the state and local level and with a small number of high profile employers. For example, IBM offers 20 weeks of paid maternity leave to both salaried and hourly workers who are birth mothers and offers 12 weeks of paid paternity leave for all other parents.4 A few states have enacted paid medical and family leave laws – California, New Jersey, New York, and Rhode Island. Additionally, a number of cities have enacted paid leave policies but most are oriented toward paid sick leave. While upwards of 20 other states have proposed their own paid leave laws, none have yet enacted a law. Regarding tax incentives to support early child care, tax law changes for 2018 raised child care tax credits up to a maximum of $2000 per child. The amount of the credit
is indexed by income level. The credits do not differentiate between medically related child care
and general day care. This provision of the tax code already allows amounts paid to certain
extended family members to be considered in the tax credit calculation under certain
circumstances. For instance, if a child was sick at home and both parents had to work, a
grandmother could provide care and if paid, the expense could be considered in the credit
calculation, but the expenses are still subject to the maximums.

AMA POLICY

AMA policy supports voluntary employer policies that provide employees with reasonable job
security and continued availability of health plan benefits in the event leave becomes necessary due
to documented medical conditions (Policy H-420.979). The AMA recognizes the public health
benefits of paid sick leave and other paid time off, although mandatory paid sick leave is not
specifically endorsed by the AMA. Council on Medical Service (CMS) Report 3-A-16 provided a
comprehensive review of sick leave and paid leave policies. The HOD adopted the
recommendations in the report, which established policy supporting employer policies that provide
employees with unpaid sick days to care for themselves or a family member (Policy H-440.823).

As it relates specifically to physician practices, AMA Policies for Parental, Family, and Medical
Necessity Leave (Policy H-405.960) established guidelines that encourage medical group practices
to incorporate and/or encourage development of leave policies, including parental, family, and
medical leave policies, as part of the physician’s standard benefit agreement.

Existing AMA policy also includes Policy H-405.954, “Parental Leave.” BOT Report 9-I-17 was
written and filed as an informational report, primarily to address possible expansion of the FMLA,
but also made reference to paid parental leave. Policy H-405.954 states that the AMA will: “(1)
courage the study of the health implications among patients if the United States were to modify
one or more of the following aspects of the Family and Medical Leave Act (FMLA) (a) a reduction
in the number of employees from 50 employees; (b) an increase in the number of covered weeks
from 12 weeks; (c) creating a new benefit of paid parental leave; and (2) study the effects of FMLA
expansion on physicians in varied practice environments.”

RESEARCH AND LEGISLATIVE ACTIVITIES

Currently, federal law does not require employers to provide paid family or parental leave. The
FMLA requires employers of a certain size to provide medically-related unpaid time off.

The most recent effort at the federal level to provide a broad paid parental leave approach is
currently stalled. The Family and Medical Insurance Leave Act (“FAMILY Act,” H.R. 947/S. 337)
was introduced in Congress in 2017. The bill would, among other things, provide paid family and
medical leave to individuals who meet certain criteria. It would be financed through a tax on every
individual and employer, and all self-employment income. Thus far, the bill has been supported by
Democratic members of Congress and has seen little action since introduction. The bill as
originally drafted would:

- Create a national program to provide all workers, regardless of company size, with up to 12
  weeks of partially paid leave; and
- Enable workers to receive up to 66 percent of their monthly wages, up to a capped amount,
  during their time of leave.
The AMA has not taken a position on this bill. In 2016 the Society for Human Resources Management (SHRM) partnered with the Families and Work Institute to conduct a National Study of Employers (NSE) practices on workplace benefits, and paid parental leave was part of that study. The study seems to be the most recent and relevant broad-based employer analysis of what policies are in place today for parental leave as well as trends for the future.

The NSE’s surveys have been conducted five times since 2005, providing both snapshots in time and current trends in employer practices and attitudes. The 2016 study samples 920 employers with more than 50 employees, with a blend of for-profit and non-profit as well as single and multi-cite locations. Note that the findings cited below all relate to employers with more than 50 employees.

The NSE noted that despite announcements of expanded parental leave benefits from Netflix, Amazon, Microsoft, Johnson & Johnson, Ernst & Young and a few others, “The media blitz over the past few years regarding paid parental leave was not representative of the majority of U.S. employers with 50 or more employees in 2016.” It also noted that the average maximum number of weeks of parental and caregiving leaves did not change significantly between 2012 and 2016, and in fact the average number of weeks provided had slightly declined when looking back to pre-recession 2005. 2016 data showed that employers seemed to be more supportive of easing the transition of a parent back into the workforce upon the birth of child (81% of employers), and more supportive of work from home options (40 percent of employers), but the percentage of employers allowing at least some employees to take time off during the workday for family or personal needs without loss of pay had declined from 87 percent to 81 percent.

Another finding demonstrated that employer support for flexible work arrangements had dropped dramatically from 31 percent in 2005 to 14 percent in 2016. While definitive research was not available to explain this change, it may be that many employers had narrowed benefit offerings during the prolonged period of economic difficulty that began in 2008. While the study tended to focus more on whether employers provided time off, it did note that of those employers providing at least some pay to women during maternity leave, most (78 percent) did so by providing some type of short term disability pay. The survey also indicated that for those employers that do offer pay, 6 percent of employers offered full pay, 39 percent offered partial pay, and 11 percent said it depends on the situation. Forty-two percent of the employers responding offered no pay at all. However, in contrast to those findings, the same report indicated that 39 percent of employers allowed employees to take time off (at least 5 days) to care for mildly ill children without having to use vacation days or losing pay. The implication of this particular data is that employer policies on paid time off lack consistency.

As articulated in Board of Trustees Report 9-I-17, there is an abundance of literature about the benefits of employee access to medical leave provided under existing law, much of which was summarized in CMS Report 3-A-16. Paid sick leave has been increasing throughout the United States whether by state or local law mandates or decisions by employers. However, paid leave to care for others outside of paid vacation, PTO (generic paid time off), or paid sick leave is still not prevalent in the US.

Given that only a handful of states have enacted paid parental leave programs, research on their effectiveness is limited. However, what little research there is has demonstrated generally neutral to positive feedback from employers. In particular, BOT Report 9-I-17 noted California’s experience:

In California, for example, the Paid Family Leave program provides employees with up to six weeks of paid leave to care for a new child or ill family member. The program is funded by employee payroll contributions, so while employers do not face financial
burden as a result of the law, they are faced with ensuring the employees’ workload is
covered and that gaps in staffing are filled. The program in California, however, does not
assure job protection during leave, provides wage replacement at only 55 percent, and
does not cover care for grandparents, grandchildren, parents-in-law, or siblings. A 10-
year review of California’s expansion demonstrated that the Paid Family Leave benefit
promoted family well-being, improved family economic security, equalized access to
leave across occupations and income levels, and bolstered businesses by reducing
workforce turnover. It was also noted that overall awareness of the program among those
most likely to utilize it was low, implying that utilization rates could be higher if
education and outreach were improved upon. Similar outcomes have been reported for
other cities and states.7-9

An analysis published by IMPAQ International, Inc. and the Institute for Women’s Policy Research
summarizes a simulation of five paid family and medical leave model programs based on working
programs in three states and a federal proposal, all applied to the national workforce. The findings
suggest that expansion of FMLA laws, through covering more eligible workers, replacing a larger
percentage of usual earnings, and offering more weeks of paid leave would increase costs. If based
on any of the five models in the simulation, the cost for benefits would range from $31 billion to
$43 billion. This report also projects that a national paid family and medical leave policy,
dependent on the type of expansion, would increase the amount of leave taken by 6 to 11 percent
annually.10

Some employer groups claim paid leave policies or policies that provide coverage for more
employees may burden and negatively impact employer operations.

When predicting employer reactions to programs, policies and benefits related to caregiving leaves
and child and elder care, the NSE research articulated four primary factors: (1) the demographics of
their workplace; (2) the demographics of the workforce; (3) financial health of the employer; and
(4) human resources issues such as the difficulty or ease of attracting and retaining employees as
well as the costs of employee benefits.

The attitude and approach of employers is fundamental to progress on a broad national approach to
paid parental leave. It is not atypical for employers to consider all four of these factors when
considering what benefits to offer their employees. As it relates to paid time off, some employers
are specific about how that time can be used (vacation, sick time). Other employers are more
flexible (“paid time off”), wherein the employer provides a bank of paid time off that employees
can use for any purpose. Employers typically review benefits offerings every year, with time off
being only one of a myriad of benefits being evaluated.

As noted above, recent changes in the federal tax code increased the child care tax credit up to
$2000 per child. While it may be debatable whether the increase goes far enough, it is a positive
step forward toward the intent of Resolution 416 and supporting the child care efforts of people
with lower economic status.

While there has been recent publicity about proposals to have some type of child care financial
assistance by allowing people to draw down future Social Security benefits, it does not seem at
present that such proposals will receive meaningful consideration in Congress.
DISCUSSION

The Board’s review of existing research has demonstrated that despite positive health outcomes for children being cared for by their parents, meaningful progress on national policy mandating paid parental leave is unlikely in the near term. The necessary broad-based support of employers to support such policy is simply not present at this point in time. Additionally, the anti-regulatory views of the current Administration and political climate in Washington DC may not be ripe for federal policy or action on paid family leave.

The first resolve of Resolution 416-A-17 asked the AMA to advocate for improved social and economic support for paid family leave to care for newborns, infants, and young children. The Board of Trustees believes that there would be considerable challenges to pursuing a public policy that would require employers to provide paid parental leave. Nevertheless, the Board believes that HOD policy supporting paid parental leave for the care of children is good public policy. Policy H-440.823 does support employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member. As noted earlier in this report, approximately 38 percent of employers currently offer paid parental leave for employees who are new parents. Accordingly, the Board of Trustees also supports encouraging employers to offer and/or to expand these types of policies. The Board believes that state medical associations should also be encouraged to work with their state legislatures to establish and promote parental leave policies.

The second resolve of Resolution 416-A-17 asked the AMA to advocate for federal tax incentives to support early child care and unpaid child care by extended family members. As previously noted in this report, recent changes to Federal tax law have raised child care tax credits to a maximum of $2000 per child, beginning in 2018. The expense of paying extended family members to perform child care can be considered in the calculation of this credit under certain circumstances.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the following be adopted in lieu of Resolution 416-A-17 and the remainder of this report be filed:

1. That our AMA reaffirm Policy H-440.823, “Paid Sick Leave,” which recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member. (Reaffirm Current HOD Policy)

2. That our AMA encourage employers to offer and/or expand paid parental leave policies. (New HOD Policy)

3. That our AMA encourage state medical associations to work with their state legislatures to establish and promote paid parental leave policies. (New HOD Policy).

Fiscal Note: Less than $500.
REFERENCES

5. Society For Human Resources Management, Families and Work Institute, National Study of Employers, 2016
INTRODUCTION

Resolution 417-A-17, “Mandatory Public Health Reporting of Law Enforcement-Related Injuries and Deaths,” introduced by the New England Delegation and the Minority Affairs Section and referred by the House of Delegates asked:

That our American Medical Association encourage the Centers for Disease Control and Prevention and state departments of health to collect data on serious law enforcement-related injuries and deaths and make law enforcement-related deaths a notifiable condition.

BACKGROUND

Legal intervention deaths represent a small portion of violent deaths (1%) and homicides (4%) in the United States each year. However, data suggest that legal intervention deaths increased 45% between 1999 and 2013. Males aged 10 or older represent 96 percent of these deaths. From 2010 – 2014, the mortality rate for legal intervention deaths among non-Hispanic Black and Hispanic individuals was 2.8 and 1.7 times higher, respectively, than that of White individuals. In the United States, there have been several recent, high-profile cases involving the use of lethal force by law enforcement, particularly in minority communities, which have led to protests and some incidents of civil unrest. These events erode the relationship between law enforcement agencies and the populations they serve.

Testimony at the reference committee hearing was mostly supportive of the intent of this resolution. However, confusion was evident regarding whether this data was already being collected, as well as around certain definitions.

Definitions

At the state level, jurisdictions can require the reporting of cases of specific infectious and noninfectious conditions to public health agencies, this is typically referred to as a “reportable condition.” A “nationally notifiable condition” refers to conditions that state health departments have agreed to voluntarily report to the Centers for Disease Control and Prevention (CDC). The Council on State and Territorial Epidemiologists, with input from CDC, maintains and periodically revises the list of nationally notifiable diseases and conditions.
Surveillance case definitions enable public health officials to classify and count cases consistently across various reporting jurisdictions. A standard, agreed upon definition of “law enforcement-related deaths” is lacking.

In the literature, such deaths are typically referred to as “legal intervention deaths,” based on the definition from the International Classification of Diseases 10th Revision (ICD-10). “Legal intervention deaths” are defined as “a death in which a person is killed by a law enforcement officer or other peace officer (i.e., a person with specified legal authority to use deadly force), including military police, while on duty.” This category excludes legal executions. It does not depend on whether the resulting injury was lawful or whether injuries were inflicted intentionally. Legal intervention death is the case definition used in reporting data on this issue to public health agencies.

Other case definitions include, “arrest-related deaths,” which captures (1) “all deaths attributed to any use of force by law enforcement personnel acting in an official agency capacity;” (2) “any death that occurs while the decedent’s freedom to leave is restricted by a state or local law enforcement agency prior to, during, or following an arrest;” and, (3) “any death that occurs while confined in lockups or booking centers.” Data on “use-of-force deaths” include “actions by a law enforcement officer as a response to resistance that results in the death or serious bodily injury of a person or when a law enforcement officer, in the absence of death or serious bodily injury, discharges a firearm at or in the direction of a person.”

Law enforcement-related deaths could also encompass law enforcement officer homicides, which are defined to capture deaths of law enforcement officers killed in the line of duty or those acting in an official capacity.

DISCUSSION

Surveillance systems can help researchers and public health agencies examine data and identify patterns or associations that can inform preventive actions. Multiple systems currently exist that collect information regarding law enforcement-related deaths. These include both governmental and non-governmental reporting systems. Governmental reporting systems are either housed in law enforcement agencies or public health agencies. Data collected varies by system, with a number of different types of cases being reported from different sources. Most non-governmental systems were created by the media to try to develop a more accurate data set than what is available from governmental reporting systems.

Governmental Reporting Systems

There are four reporting systems that have been used by the government to collect data on law enforcement-related deaths, the Federal Bureau of Investigation’s (FBI’s) Uniform Crime Reporting (UCR) program, the Bureau of Justice Statistics (BJS) Arrest-Related Deaths (ARD) program, the CDC’s National Vital Statistics System (NVSS), and National Violent Death Reporting System (NVDRS).

The BJS ARD program was designed as an annual, national census of persons who died during the process of arrest or while in the custody of state or local law enforcement. In addition to deaths caused by the use of force by law enforcement personnel, it also captures those not directly related to law enforcement action, such as suicide, intoxication, accidental injury, illness, or natural causes. ARD was established as a state-based reporting system in which state reporting coordinators in all 50 states and the District of Columbia are responsible for identifying and reporting all eligible...
In 2014, BJS determined that the ARD data did not meet BJS data quality standards, and therefore suspended data collection and publication. In 2016, BJS announced a program redesign which relies on a mixed method, hybrid approach involving data collected from media sources and reporting from law enforcement agencies.

The FBI’s UCR program collects data from more than 18,000 law enforcement agencies nationwide and reports information on law enforcement officers killed and assaulted, justifiable homicide, and crime data statistics. The FBI has agreed to work with other organizations, including the BJS and the law enforcement community, to gather and report data on officer-involved use-of-force incidents. Participation is open to all local, state, tribal, and federal law enforcement and investigative agencies. Each law enforcement agency will be responsible for reporting information for its own officers connected to incidents that meet the criteria of the data collection. The goal is to provide an aggregate view of the incidents reported and the circumstances, subjects, and officers surrounding the incidents.

The CDC’s NVDRS is a state-based surveillance system that links information on violent deaths, including legal intervention deaths, from three required sources – death certificates, coroner/medical examiner reports, and law enforcement reports – into a single system to create a more complete picture of the circumstances that lead to violent death. NVDRS also captures homicides of law enforcement officers. Currently 40 states, the District of Columbia, and Puerto Rico are funded under a cooperative agreement with CDC to operate NVDRS. The goal is to eventually have a national system, with all 50 states, U.S. territories and the District of Columbia funded to participate.

The CDC’s NVSS has captured legal intervention deaths since 1949. NVSS receives electronic mortality data from death certificates from all 50 states, the District of Columbia, New York City, and 5 territories. The NVSS’ reliance on death certificate data has resulted in the underreporting of legal intervention deaths due to coroners or medical examiners failing to mention police involvement in the death certificate’s cause of death section or possibly due to coding errors at the CDC’s National Center for Health Statistics.

A number of non-governmental systems have begun to track legal intervention deaths in the United States because a comprehensive national database is lacking. The Counted, a project by the Guardian, seeks to count the number of people killed by police and other law enforcement agencies in the United States through verified, crowdsourced information. The Washington Post’s Fatal Force database tracks fatal shootings by U.S. police officers. Fatal Encounters, has sought to create a comprehensive national database of people who are killed through interactions with law enforcement since January 1, 2000. These systems utilize media reports, public records, and social media reports to help identify cases.

In Tennessee, the state bureau of investigation is required to provide the commissioner of health and the general assembly a report on all law enforcement-related deaths that occurred in the prior calendar year. “Law enforcement-related deaths” is defined to include: (1) the death of an individual in custody, whether in a prison, in a jail or otherwise in the custody of law enforcement pursuant to an arrest or a transfer between institutions of any kind, or (2) the death of an individual potentially resulting from an interaction with law enforcement, while the law enforcement officer is on duty or while the law enforcement officer is off duty, but performing activities that are within
the scope of the officer’s law enforcement duties, without regard to whether the individual was in custody or a weapon was involved. While jurisdictions participating in NVDRS are required to report legal intervention deaths and law enforcement officer homicides, Tennessee appears to be the only state with a statute in place requiring the reporting of legal intervention deaths to the public health agency.

CONCLUSION

Various reporting systems exist to capture a range of different types of law enforcement-related deaths. However, no one system or case definition is perfect. Resolution 417-A-17 specifically relates to public health surveillance. NVDRS and NVSS are the existing public health reporting systems that capture legal intervention deaths and law enforcement officer homicides. Both systems have their strengths and weaknesses. NVDRS captures information from multiple sources and is therefore less likely to miss cases. However, it is not currently a national system. NVSS is a national system, but uses data from death certificates, which are often inaccurate or incomplete.

Since NVDRS is a more comprehensive public health surveillance system that collects information on both legal intervention deaths and law enforcement officer homicides, it makes sense to encourage its expansion to all states and territories. NVDRS is a state-based surveillance system; therefore it also seems reasonable to encourage the reporting of this information to state public health agencies. Increased public health surveillance will be useful for measuring the need for and effects of interventions to address such deaths.

CURRENT AMA POLICY

Existing AMA Policy H-515.955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes,” encourages the National Academies of Sciences, Engineering, and Medicine to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities and encourages the CDC as well as state and local health departments to research the nature and public health implications of violence involving law enforcement. Policy H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” supports increasing funding for and the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 417-A-17 and the remainder of the report be filed.

1. That current AMA Policy H-515.955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes,” be amended by addition and deletion to read as follows:

H-515.955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes”
Our AMA: 1. Our AMA encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities. 2. Our AMA affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social
Our AMA encourages the Centers for Disease Control and Prevention as well as state and local public health departments and agencies to research the nature and public health implications of violence involving law enforcement. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies. (Modify Current HOD Policy)

2. That current AMA Policy, H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” which supports increased funding for and the expansion of the National Violent Death Reporting System to all 50 states and territories be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


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

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the HOD modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset. (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification. (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports. (3) Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished. (4) The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices. (5) The most recent policy shall be deemed to supersede contradictory past AMA policies. (6) Sunset policies will be retained in the AMA historical archives.
In this report, the Council on Science and Public Health (CSAPH) presents its recommendations on the disposition of the HOD policies from 2008 that were assigned to it. The CSAPH’s recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500
### APPENDIX: Recommended Actions on 2008 House Policies and Directives

<table>
<thead>
<tr>
<th>Policy/Directive Number</th>
<th>Title</th>
<th>Recommended Action and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-115.991</td>
<td>Manufacturer Labeling of Medical Supplies</td>
<td>Rescind. Accomplished by Unique Device Identifier regulations.</td>
</tr>
<tr>
<td>D-15.999</td>
<td>Options for Improving Motorcycle Safety</td>
<td>Retain in part. Part 1 was accomplished by NHTSA’s publishing in November 2006 of national motorcycle guidelines. Retain part 2 and amend to H-policy. Our AMA: (1) encourages the National Highway Traffic Safety Administration to work with medical and public health organizations, national motorcycle rider organizations, state motor vehicle licensing agencies, law enforcement officials, and the motorcycle industry to develop a comprehensive national motorcycle safety plan that addresses rider education, training, and licensing; use of motorcycle helmets and other protective gear; public awareness of motorcycles; alcohol use among motorcyclists and other motor vehicle drivers; measures to increase the visibility of motorcyclists and motorcycles to other drivers; engineering and design of motorcycles and highway environments; and research to determine the effectiveness of current and proposed safety measures; and (2) encourages physicians to (a) be aware of motorcycle risks and safety measures and (b) counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs.</td>
</tr>
<tr>
<td>D-155.999</td>
<td>Energy Efficiency and Medical Practice</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-165.997</td>
<td>Physician Education of Their Patients About Prescription Medicines</td>
<td>Rescind. Accomplished by support and dissemination of Guidelines for Physicians for Counseling Patients about Prescription Medications in the Ambulatory Setting.</td>
</tr>
<tr>
<td>D-170.998</td>
<td>Alcohol and Youth</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-20.990</td>
<td>Global HIV/AIDS Prevention</td>
<td>Retain in part to read as follows and change to H-policy: Our AMA extends its support of comprehensive family-life education to foreign aid programs to prevent the spread of HIV/AIDS and other sexually transmitted diseases.</td>
</tr>
<tr>
<td>D-20.998</td>
<td>Bloodborne Pathogen Transmission to and from</td>
<td>Rescind. The CDC published updated recommendations for the Hepatitis B Virus–infected health care providers.</td>
</tr>
<tr>
<td>Code</td>
<td>Issue</td>
<td>Resolution/Comments</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| D-425.999 | Public and Private Funding of Prevention Research | Retain in part to read as follows and change to H-policy:  
(1) Our AMA will seek to work in partnership with the Centers for Disease Control and Prevention, the National Institutes of Health, and other Federal Agencies, the Public Health Community (via the medicine/public health initiative), and the managed care community to ensure that there is a national prevention research agenda and report back to the House of Delegates the current status of this agenda. (2) These groups work in partnership to develop a practical plan to implement recommendations which will allow such groups to support and participate more fully in prevention research. |
| D-470.992 | Implementation of Automated External Defibrillators in High-School and College Sports Programs | Retain. Only 17 of 50 states have some type of legislation dealing with AEDs in schools, most commonly a requirement for AEDs in public grade schools or in both public grade schools and colleges. |
| D-490.998 | Tobacco Control and Settlement | Retain. Still an important issue.                                                                          |
| D-495.996 | Opposition to Addition of Flavors to Cigarettes | Retain. Change to H-policy.                                                                               |
| D-515.984 | Health Care Costs of Violence and Abuse Across the Lifespan | Retain in part to read as follows and change to H-policy:  
1. Our AMA urges Congress the National Academies of Sciences, Engineering, and Medicine to continue to support the Institute of Medicine to continue to study and issue a report on the impact and health care costs of violence and abuse across the lifespan.  
2. Our AMA encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse; and (b) will develop and implement a strategy to advocate for increased funding for such research.  
3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment. |
| D-55.997 | Cancer and Health Care Disparities Among Minority Women | Retain in part to read as follows and change to H-policy:  
Our AMA+(b) encourages research and funding directed at addressing racial and ethnic disparities in |
<table>
<thead>
<tr>
<th>Code</th>
<th>Issue</th>
<th>Action/Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-60.971</td>
<td>Reduction of Underage Drinking</td>
<td>Retain. Change to H-policy.</td>
</tr>
<tr>
<td>D-60.972</td>
<td>Internet Marketing to Children on Health</td>
<td>Rescind. Online tools exist to educate children about health habits and lifestyles.</td>
</tr>
<tr>
<td>D-95.982</td>
<td>Drug Abuse and Relapse Reduction Through Patient Identifiers as a Chronic Disease</td>
<td>Retain in part to read as follows because a portion is no longer relevant and change to H-policy:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Our AMA: (1) strongly urges health care providers to take an active role in acknowledging the diagnosis of addiction is a chronic disease; and (2) will partner with organizations such as the American Society of Addiction Medicine, to explore the use of medication contracts to monitor the use of prescribed medications in patients with a known history of addiction.</td>
</tr>
<tr>
<td>D-95.984</td>
<td>Substance Use and Substance Use Disorders</td>
<td>Retain. Change to H-policy.</td>
</tr>
<tr>
<td>H-10.970</td>
<td>Use of Protective Eyewear by Athletes</td>
<td>Retain. AAP and AAO policies remain in place.</td>
</tr>
<tr>
<td>H-10.989</td>
<td>Better Fire Prevention in Public Buildings</td>
<td>Retain in part to read as follows: The AMA urges state public authorities to consider enactment of uniform fire protection codes in public buildings, for the risks such furnishings hold for the emission of toxic gases as well as intense heat, and at least in the case of new construction, the introduction of expanded sprinkler systems and fully automatic smoke detectors.</td>
</tr>
<tr>
<td>H-100.970</td>
<td>Informational Campaign on Diethylstilbesterol</td>
<td>Rescind. CDC program is no longer in place.</td>
</tr>
<tr>
<td>H-100.985</td>
<td>Need for Requirements of Ongoing Quality Assurance of the Bioavailability of Purity of Prescription Pharmaceuticals</td>
<td>Rescind. Appropriate regulations are in place.</td>
</tr>
<tr>
<td>H-100.989</td>
<td>A Transitional Class for Drugs</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-125.981</td>
<td>Generic Medications</td>
<td>Retain in part to read as follows: Our AMA encourages the Food and Drug Administration to reexamine the maintain standards and criteria used for approving generic medications to</td>
</tr>
<tr>
<td>H-125.995</td>
<td>Therapeutic and Pharmaceutical Alternatives by Pharmacists</td>
<td>Retain in part to read as follows: The AMA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a drug product, to: (1) dispense instead a drug product that is administered by the same route and which contains the same pharmaceutical moiety and strength, but which differs in the salt or dosage form (pharmaceutical alternatives); and (2) dispense a drug product containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution). Our AMA will work with state medical associations to ensure that state pharmacy laws and medical practice acts are properly enforced so that a treating physician's prescription directions cannot be overruled or substituted without prior physician approval. If this issue is not addressed in existing laws, our AMA will develop model legislation to assist state medical associations in this endeavor.</td>
</tr>
<tr>
<td>H-130.943</td>
<td>Physician Identification in Emergencies</td>
<td>The center is no longer operational. Retain in part to read as follows: Our AMA, through the Center on Public Health Preparedness and Disaster Response, will continue to: (1) monitor the development of volunteer registration systems, such as Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), as well as volunteer organizations, such as the Medical Reserve Corps (MRC), and report back as appropriate; and (2) support the development of laws and policies such as license reciprocity and civil liability protections that encourage physicians to volunteer services during disasters.</td>
</tr>
<tr>
<td>H-135.952</td>
<td>Manganese in Gasoline</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-145.994</td>
<td>Control of Non-Detectable Firearms</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-145.995</td>
<td>Ban Realistic Toy Guns</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-15.998</td>
<td>Driver Education in Secondary Schools</td>
<td>Rescind. State departments of motor vehicles have the authority to approve driver education courses that are in</td>
</tr>
<tr>
<td>Code</td>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>H-150.942</td>
<td>Rating System for Processed Foods</td>
<td>Rescind. Food label requirements have changed.</td>
</tr>
<tr>
<td>H-150.965</td>
<td>Eating Disorders</td>
<td>Retain. Still a societal issue.</td>
</tr>
<tr>
<td>H-150.975</td>
<td>Dangerous Health and Diet Books</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-160.932</td>
<td>Asthma Control</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-20.905</td>
<td>HIV/AIDS Research</td>
<td>Retain in part to read as follows:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Information on the HIV Epidemic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Our AMA:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a) Vigorously supports the need for adequate government funding for research, both basic and clinical, in relation to HIV/AIDS epidemic. Research on HIV should be prioritized, funded, and implemented in an expeditious manner consistent with appropriate scientific rigor, and the results of research should form the basis for future programs of prevention and treatment;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Requests the Secretary of the Department of Health and Human Services to make available information on HIV expenditures, services, programs, projects, and research of agencies under his/her jurisdiction and, to the extent possible, of all other federal agencies for purposes of study, analysis, and comment. The compilation should be sufficiently detailed that the nature of the expenditures can be readily determined;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) Supports ongoing efforts of the Centers for Disease Control and Prevention to periodically monitor the incidence and prevalence of HIV infection in the U.S. population as a whole, as well as in groups of special interest such as adolescents and minorities;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) Encourages federal and state agencies, in cooperation with medical societies and other interested organizations, to study and report means to increase access to quality care for women and children who are HIV-infected;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e) Encourages further research to assess the risk of HIV transmission in specific surgical techniques and how any such risk may be decreased;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f) Supports exploring ways to increase public awareness of the benefits of animal studies in HIV/AIDS research.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Lookback Studies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Our AMA encourages the cooperation of the medical community and patients in scientifically sound lookback studies designed to further define the risk of HIV transmission from an infected physician to a patient and</td>
</tr>
</tbody>
</table>
to determine if there is any scientific basis for the development of a list of exposure-prone procedures. A panel of experts should be assembled to translate available look-back information into a meaningful statement on the estimated true risk of transmission and the need, if any, for additional studies.

(3) Community Research Initiatives

Our AMA supports the objectives of community-based research to reduce HIV disease and encourages periodic review of progress toward these objectives.

| H-275.939 | Internet Gambling | Retain in part to read as follows: Our AMA: (1) informs physicians and patients of the dangers of addiction associated with Internet gambling; (2) supports the prohibition of government-sponsored Internet gambling; and (3) in collaboration with appropriate specialty societies, pursues other avenues to and supports prohibiting the availability of Internet gambling to children. |
| H-280.963 | Drug Regimen Review in Long Term Care Settings | Retain. Still relevant. |
| H-345.990 | Electroconvulsive Therapy | Retain. Still relevant. |
| H-420.977 | Posting of Warnings Against Use of Alcohol During Pregnancy | Retain. Still valid. |
| H-425.974 | Appropriate Aspirin Use for Prevention of Heart Disease and Stroke | Retain. Still relevant. |
| H-425.990 | Prevention of Coronary Artery Disease | Retain. Physician oversight is encouraged. |
| H-440.862 | Immunization Access to Parents of High-Risk Infants Younger than Six Months of Age | Retain. Still relevant. |
| H-440.901 | Achieving National Adolescent Immunization Goals | Retain. An important goal. |
| H-440.957 | Reporting Potential for Hearing Loss Due to Personal Listening Devices | Retain in part to read as follows: It is the policy of the AMA that (1) physicians counsel patients about the potential loss of hearing associated with the misuse of personal listening devices; (2) research be directed at more specific definition of the relationship between acute and chronic use of personal |
| H-440.998 | US Public Health Service | Retain. Consistent with AMA’s views. |
| H-440.999 | Increase in Venereal Disease | Retain. Pending policy consolidation. |

| H-45.980 | Airborne Infections on Commercial Flights | Retain in part to read as follows: (1) Under usual aircraft operation procedures, cabin air quality does not present a significant risk for transmission of airborne infections. (2) The AMA supports efforts of the Aerospace Medicine Medical Association and other groups to determine standards for cabin air quality and educate physicians and the public about the public health risks associated with flying with airborne transmissible diseases. (3) The AMA supports the ongoing research of organizations such as the American Society of Heating, Refrigeration and Air Conditioning Engineers and the National Institute of Occupational Safety and Health to determine standards for cabin air quality. |

| H-455.991 | Physician Training for Management of Injuries Encountered in Nuclear Explosions Radiological Incidents | Retain in part to read as follows: The AMA supports educating and training physicians in the management of injuries that may be encountered in isolated related to radiological nuclear incidents. |

| H-460.910 | Systemic Lupus Erythematosus Research and Its Impact on Minority Health | Retain in part to read as follows: Our AMA: (1) supports increased funding for biomedical research and educational programs that work toward finding the cause and a cure for lupus; and (2) will collaborate with medical specialty societies and federal organizations, including the Office of Research on Women's Health at the National Institutes of Health, involved with research and educational initiatives pertaining to lupus. |
| H-460.923 | Melanoma Registry | Rescind. A process is established. All states require physicians to report cases of melanoma to their central cancer registry. |

| H-460.930 | Council on Scientific Affairs Conference: “Importance of Clinical Research” | Retain in part to read as follows: (1) Given the profound importance of clinical research as the transition between basic science discoveries and... |
| **Assessing the Future in a Changing Environment** | standard medical practice of the future, the AMA will a) be the principal advocate for clinical research; b) promote the importance of this science and of well-trained researchers to conduct it; and c) facilitate communication among different organizations and groups, including managed care organizations, that are essential for broad-based support of clinical research.  
(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, Health Care Policy and Research, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.  
(3) Traditional sources of financial support for clinical research and for academic health centers are diminishing significantly in the evolving health care environment of the 1990s. All endeavors that depend upon development of new knowledge and technologies for their continued success recognize the need to devote a proportion of revenue for research and development. The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.  
(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.  
(5) Our AMA believes that one obligation of organized medicine and physicians is to support clinical research, as the basis of advances in medicine. To facilitate this, the AMA should explore ways physicians and physician organizations can encourage and assist in educating the public about the importance of clinical research such as through educational materials and programs for children and schools.  
(6) Our AMA encourages and supports development of community and practice-based clinical research networks. |

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-470.998</td>
<td>Youth Physical Fitness</td>
<td>Rescind. Still an issue.</td>
</tr>
<tr>
<td>H-480.962</td>
<td>Patient Access to Devices Pending Approval</td>
<td>Rescind. Processes are in place for expanded access to medical devices.</td>
</tr>
<tr>
<td>H-490.911</td>
<td>Smoke-Free America</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-495.976</td>
<td>Opposition to Exempting the Addition of Menthol to Cigarettes</td>
<td>Retain in part to read as follows: Our AMA: (1) will continue to support the Food and Drug Administration (FDA) legislation as amended by the House of Representatives and urge its passage and enactment as soon as possible as a major step forward in regulating tobacco products and the harm they create; (2) shall immediately petition the FDA to conduct inquiries and take steps to a ban on the use and marketing of menthol in cigarettes as a harmful additive, if the current bill is passed without the menthol amendment, once enacted into law; and (3) encourages and will assist its members to seek state bans on the sale of menthol cigarettes regardless of whether the current FDA legislation is enacted.</td>
</tr>
<tr>
<td>H-50.986</td>
<td>Blood Donations by Donors over 65 Years of Age</td>
<td>Rescind. No upper limit exists on the age for blood donation.</td>
</tr>
<tr>
<td>H-50.998</td>
<td>Definition of Blood as a Medical Service</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-50.999</td>
<td>Blood Banks</td>
<td>Rescind. Strict regulatory oversight in place.</td>
</tr>
<tr>
<td>H-55.988</td>
<td>Uniform Cancer Staging</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-60.931</td>
<td>Toy Safety</td>
<td>Rescind. Toy safety standards in place.</td>
</tr>
<tr>
<td>H-60.932</td>
<td>Ensuring the Best In-School Care for Children with</td>
<td>Retain. Still important.</td>
</tr>
<tr>
<td>Bill Number</td>
<td>Issue Description</td>
<td>Retained Status</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>H-60.947</td>
<td>Guns in School Settings</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-60.958</td>
<td>Rights of Minors to Consent for STD/HIV Prevention, Diagnosis and Treatment</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-60.989</td>
<td>Sexually Oriented Advertising to Youth</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-60.990</td>
<td>Child Pornography</td>
<td>Retain. Still an issue.</td>
</tr>
<tr>
<td>H-95.951</td>
<td>Role of Self-Help in Addiction Treatment</td>
<td>Retain in part to read as follows: The AMA: (1) recognizes that (a) patients in need of treatment for alcohol or other drug-related substance use disorders should be treated for these medical conditions by qualified professionals in a manner consonant with accepted practice guidelines and patient placement criteria; and (b) self-help groups are valuable resources for many patients and their families and should be utilized by physicians as adjuncts to a treatment plan; and (2) urges managed care organizations and insurers to consider self-help as a complement to, not a substitute for, treatment directed by professionals, and to refrain from using their patient’s involvement in self-help activities as a basis for denying authorization for payment for professional treatment of patients and their families who need such care.</td>
</tr>
<tr>
<td>H-95.980</td>
<td>Increased Funding for Drug-Related Programs</td>
<td>Retain. Still relevant.</td>
</tr>
</tbody>
</table>
REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-A-18

Subject: The Physician’s Role in Firearm Safety

Presented by: Robert A. Gilchick, MD, MPH, Chair

Referred to: Reference Committee D (Shannon Kilgore, MD, Chair)

INTRODUCTION

In March 2017, the American Medical Association (AMA) and the American Bar Association co-sponsored a conference titled, “Preventing Gun Violence: Moving from Crisis to Action.” The conference was attended by members of the Council on Science and Public Health (Council) and the findings of this conference served as the impetus for developing this report as a Council initiative.

The Council previously studied the issue of preventing violence against health care workers and issued recommendations (see Policy H-515.957, “Preventing Violent Acts Against Health Care Providers”). That topic is not further addressed in this report.

METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2013 to January 2018 using the search terms “gun violence,” “firearm safety,” “firearm violence,” “physician” and “firearm,” “physician” and “gun,” “suicide” and “gun” or “firearm”, “children” and “firearm safety,” “gun violence restraining order,” and “domestic violence restraining order.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations also were reviewed for relevant information.

CURRENT AMA POLICY

As one of the main causes of intentional and unintentional injuries and deaths, the AMA recognizes that firearms are a serious public health problem in the United States. The AMA has extensive policy on firearm safety and prevention of gun violence. Relevant to this report is existing policy that affirms the rights of physicians to have free and open communication with their patients regarding firearm safety and that calls on physicians to educate and counsel patients about firearm safety. AMA policy also supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to inquire about the presence of household firearms as a part of childproofing the home and routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms. AMA policy also urges Congress to provide sufficient resources to enable the Centers for Disease Control and Prevention (CDC) to collect and analyze data on firearm-related injuries in order to help prevent injury, death and the other costs to society resulting from firearms.
Firearm-related deaths are the third leading cause of injury-related deaths in the United States. In 2016, more than 38,000 persons died from injury by firearms in the United States.\textsuperscript{1} While mass shootings are horrific, they represent a small percentage of firearm-related deaths (less than 1 percent). Firearm suicide deaths, on the other hand, constitute more than 60 percent of firearm deaths, with firearm homicides accounting for approximately 35 percent, and accidental firearm deaths accounting for approximately 1.5 percent.\textsuperscript{1,2}

Males disproportionately bear the burden of firearm mortality, accounting for 86 percent of all victims of firearm death.\textsuperscript{2} Young adults between the ages of 25 and 34 years have the highest rate of fatal firearm injury per 100,000 at 15.1, followed by those in the 15 to 24 year age group (14.4 per 100,000).\textsuperscript{2} Rates of firearm homicide are highest among adolescents (8.9 per 100,000) and young adults (8.0 per 100,000) and tend to decrease with age.\textsuperscript{2} Rates of firearm suicide tend to increase with age. The annual rate of firearm suicide was highest among persons aged 65 years and older (10.9 per 100,000) followed by those in the 55–64 year age group (9.4 per 100,000) and the 45–54 year old age group (9.2 per 100,000).\textsuperscript{2}

Non-Hispanic blacks have the highest rates of firearm mortality overall (18.1 per 100,000), and this disparity is largely due to differences between racial/ethnic groups in firearm homicide.\textsuperscript{2} Non-Hispanic whites (9.2 per 100,000) and non-Hispanic American Indian/Alaskan Native populations (7.8 per 100,000) have the highest rates of firearm suicide in the United States when compared to other groups.\textsuperscript{2} Non-Hispanic white males account for the majority of firearm suicides.\textsuperscript{2}

Although limited data are available to evaluate epidemiological trends for firearm-related injuries, it is estimated that more than 84,000 people suffered nonfatal firearm injuries in 2015.\textsuperscript{3} A study utilizing data from the Nationwide Emergency Department Sample identified 150,930 people in the period 2006-14 who presented alive to the emergency department (ED) with a firearm-related injury, representing an estimated 25.3 ED visits per 100,000 people. The incidence of ED visits for firearm-related injuries varied by patient age. It was the lowest among patients younger than age 10 (less than 1.5 ED visits per 100,000) and the highest among patients ages 15–29 (66.4 ED visits per 100,000).\textsuperscript{4} The incidence of firearm-related injuries was approximately nine-fold higher among male patients.\textsuperscript{4}

The majority of patients who presented alive to the ED for a firearm-related injury were injured in an assault (49.5 percent) or unintentionally (35.3 percent). Attempted suicides and legal interventions accounted for 5.3 percent and 2.4 percent respectively.\textsuperscript{4} Among all patients presenting to the ED with a firearm-related injury, 48.0 percent were discharged home and 7.7 percent were discharged to additional care facilities, while 37.2 percent were admitted to inpatient care and 5.2 percent died during their visit.\textsuperscript{4} The financial burden associated with firearm-related injuries was estimated to be approximately $2.8 billion per year.\textsuperscript{4}

PHYSICIAN COUNSELING

Households with firearms exhibit an increased risk of experiencing a homicide, suicide, or accidental firearm death of a household member.\textsuperscript{3} While physicians counsel patients about a wide range of behaviors and conditions, a systematic review of the literature found that despite clinical acceptance of the need for firearm injury prevention among high-risk populations, screening and counseling to increase safety is performed by a minority of clinicians.\textsuperscript{6} A number of barriers exist that may contribute to the lack of physician counseling on firearm safety. These include legal barriers, the lack of training and time, low expectancy that counseling is effective, uncertainty...
regarding what to say to patients, and a desire to not offend patients.\textsuperscript{6,7} As with many other behavioral interventions, clinicians who have high confidence in, and self-efficacy toward, counseling are more likely to screen.\textsuperscript{6}

\textbf{The Law Does Not Prohibit Counseling}

While a number of states have considered laws limiting what physicians are allowed to ask their patients about firearms, Florida is the only state that enacted such a law, the Firearm Owners’ Privacy Act (FOPA), which prohibited health care practitioners from inquiring about the ownership of a firearm.\textsuperscript{8} An exception included in the law allowed practitioners who in good faith believed that the information was relevant to the patient’s medical care or safety, or the safety of others, to inquire.\textsuperscript{9} In 2017, the Eleventh Circuit Court of Appeals overturned the law, holding that FOPA’s content-based restrictions violated the First Amendment as it applies to the states.\textsuperscript{9}

Montana, Missouri, and Minnesota have laws around the collection of firearm information by health practitioners; none of these laws prohibit counseling. Minnesota’s law prohibits the commissioner of health from collecting data on individuals regarding lawful firearm ownership or data related to an individual’s right to carry a weapon.\textsuperscript{10} Missouri’s law prohibits health care professionals from disclosing information about the status of a patient as an owner of a firearm, unless medically indicated or necessitated.\textsuperscript{11} Montana’s law provides that health care providers may not refuse to provide health care to a person who declines to answer questions regarding firearm ownership, possession, or use.\textsuperscript{12}

\textbf{HIGH-RISK INDIVIDUALS}

Little guidance is available regarding who should be screened for the risk of firearm injury.\textsuperscript{6} The American Academy of Pediatrics (AAP) recommends that pediatricians incorporate questions about the presence and availability of firearms into patient histories and counsel parents about the dangers of allowing children to have access to firearms both inside and outside of the home.\textsuperscript{13} Studies indicate that screening among high-risk populations may help identify patients at risk of firearm injury.\textsuperscript{6} Risk factors for firearm injury include suicidal ideation or intent, homicidal ideation or intent, history of violence, alcohol or drug use disorder, mental illness, and conditions impairing cognition and judgment.\textsuperscript{7}

\textbf{Intimate Partner Violence (IPV)}

Firearms in a violent home increase the likelihood that IPV incidents will result in death.\textsuperscript{14,15} In 2013, approximately half of the 1,270 reported intimate partner homicides in the United States were committed with firearms.\textsuperscript{15} Because of this risk, laws have been enacted to remove firearms from those who commit IPV. At the federal level, the Violent Crime Control and Law Enforcement Act of 1994 prohibits individuals subject to certain restraining orders from purchasing or possessing a firearm.\textsuperscript{16} Furthermore, the Lautenberg Amendment makes it illegal for individuals convicted of misdemeanor domestic violence assault to purchase or possess firearms. However, there are a number of gaps in the federal law, including that it does not apply to non-spouse partners.

\textbf{Mental Illness}

According to the American Psychiatric Association, reasonable restrictions on gun access are appropriate, but should not be based solely on a diagnosis of mental disorder.\textsuperscript{17} Diagnostic categories vary widely in the symptoms, impairments, and disabilities of affected individuals and a
considerable heterogeneity exists. Furthermore, individuals with mental illness, when appropriately treated, do not pose an increased risk of violence over the general population.

Suicidal Ideation

Suicide is a leading cause of preventable death in the United States and firearms are among the most lethal suicide attempt methods, with nearly 9 out of 10 attempts resulting in death. In 2015, firearms were the most common method used in suicide deaths in the United States, accounting for almost half of all suicide deaths. Over the past 15 years, the total suicide rate has increased 24 percent from 10.5 to 13.0 per 100,000. The suicide rate among males has remained approximately four times higher (20.7 per 100,000 in 2014) than among females (5.8 per 100,000 in 2014).

Physicians and other health professionals should be trained to assess and respond to individuals who may be at heightened risk for violence or suicide. In the context of suicide prevention, “lethal means counseling” refers to assessing whether a person at risk for suicide has access to a firearm or other lethal means and then working with them, their family, and support system to limit their access until they are no longer at elevated risk. Counseling of suicidal patients or (for youth) their parents about restricting “lethal means” may increase rates of firearm removal from the home.

Community Violence/Assault

High-risk youth presenting to an urban emergency department (ED) for assault have elevated rates of subsequent firearm violence. Nearly 60 percent of assault-injured youth report violent firearm aggression, victimization, and/or firearm injury within 2 years of their index ED visit. Among assault-injured youth seeking urban ED care, nearly 25% report having a firearm. Retaliation may be a significant motivation for ensuing firearm violence. This underscores the need for ED screening of retaliation risk and interventions that focus on alternative means of conflict resolution.

Childhood Injury Prevention

The most effective measure to prevent suicide, homicide, and unintentional firearm-related injuries to children and adolescents is the absence of firearms from homes and communities. The AAP encourages firearm screening as a standard part of universal injury prevention screening. Parents who possess firearms should be urged to prevent access by children because safer storage of firearms reduces injuries. Physician counseling linked with distribution of cable locks appears to increase safer storage.

Cognitive Decline

Firearm access can pose a risk to cognitively-impaired individuals. It is estimated that as many as 60 percent of older people with dementia live in a home with a firearm, where there may be a greater likelihood that they are not locked or unloaded. The Alzheimer’s Association suggests screening for firearm access along with other safety topics (i.e., driving) as well as keeping firearms locked, with ammunition stored separately.

DISCUSSION

The federal Gun Control Act makes it unlawful for certain categories of persons to ship, transport, receive, or possess firearms or ammunition. Those categories include, but are not limited to individuals convicted of a felony; unlawful users or those with addiction involving any controlled
substance; individuals adjudicated as a “mental defective” or under an order of civil commitment; individuals subject to a court order restraining them from harassing, stalking, or threatening an intimate partner or child of the intimate partner; or persons who have been convicted of a misdemeanor crime of domestic violence. However, inconsistencies in states’ reporting of disqualifying records to the National Instant Criminal Background Check System, as well as loopholes in the requirements for background checks prior to a firearm purchase, contribute to the unsuccessful identification of people who should not have firearms. Furthermore, the background check system was designed to prevent someone from purchasing a new firearm; it does not grant the authority to remove firearms from a high-risk individual who already possesses them. A number of policies have been developed to help address those gaps.

Temporary Firearm Transfer

Reducing access to lethal means is an effective, evidence-based method for suicide prevention. Most states allow the private transfer of firearms without a background check, but 19 states and Washington, DC, have universal background check (UBC) laws mandating a background check whenever a firearm is transferred. While these laws make it harder for high-risk persons to acquire firearms, they could make it more difficult for patients to temporarily transfer a firearm to reduce access to lethal means. Some UBC states have mechanisms that facilitate temporary transfers without a background check to certain persons (i.e., family members) or for certain time periods (e.g., 72 hours), but others do not. In states with rigid UBC laws, physicians should understand existing background check requirements and exceptions so they can offer tailored advice to lower the risks facing their patient.

Gun Violence Restraining Orders (GVROs)

GVRO laws, also referred to as firearm restraining orders and extreme risk protection orders, give law enforcement, family members, or household members who observe an individual’s dangerous behavior and believe it could be a precursor to violence (against themselves or others), the authority to petition a court to temporarily remove firearms from the individual’s possession and prohibit them from purchasing a new firearm or ammunition. The purpose is to target high-risk individuals on the basis of behavior, regardless of mental illness diagnosis, to reduce firearm violence. Four states (Connecticut, Indiana, California, and Washington) have adopted this risk-based, preemptive approach to firearm removal. Similar laws have been introduced in 22 other states and the District of Columbia.

In 1999, Connecticut was the first state to authorize law enforcement to petition for the removal of firearms from individuals due to “a risk of imminent personal injury to himself or herself or to other individuals.” Connecticut’s law was challenged in the courts, but was upheld by the Connecticut Appellate Court as not restricting the rights of law-abiding citizens to use arms in defense of their homes and thus, not in violation of the Second Amendment.

An evaluation of Connecticut’s risk-warrant law shows that from 1999–2013, 762 risk-warrants were issued. Almost all gun removal subjects were male (92 percent). Nearly half of the firearm removal cases were initiated by an acquaintance, with family members initiating 41 percent of cases, and employers or clinicians initiating eight percent of cases. Suicidality or self-injury threat was listed as a concern in sixty-one percent of cases, with the risk of harm to others a concern in thirty-two percent of cases. Most risk-warrant subjects did not have contact with the public behavioral health system in the year before the risk-warrant was served. However, in the year following firearm removal, nearly one-third (29 percent) of risk-warrant subjects received treatment in the state system, suggesting the risk-warrant provided an entryway into needed mental
health and substance use related services. In nearly all cases (99 percent), police found and removed firearms when they conducted a search, with an average of seven firearms removed per subject. It is estimated that there was one averted suicide for every 10 to 11 firearm removals—saving 72 lives over a 14 year period.

**Firearm Safety Programs**

Eighteen states have child access prevention (CAP) laws. These laws mandate that a firearm be stored so that a child or teen (the specific age varies by state) is not able to gain easy access to the firearm. CAP laws do not typically mandate a specific storage method, although unloading the firearm and locking it up separately from the ammunition is recommended by some researchers. State CAP laws have been associated with lower rates of both accidental deaths of children and suicides among teens.

**RESOURCES AND RELATED ACTIVITIES**

At A-17, the House of Delegates adopted policy calling on the AMA to work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death. In addition to this report, the Council is sponsoring an educational session at A-18 on “Preventing Gun Violence: What Physicians Can Do Now.” The AMA is also in the process of developing an enduring continuing medical education (CME) module to help physicians navigate conversations with their patients on firearm safety. The CME module is expected to be available on the AMA’s education center portal by the end of the year. The AMA is also working to provide physicians with state-specific guidance on firearm laws and how those laws interact with firearm safety counseling.

Other resources of interest include, “What You Can Do,” a new initiative from University of California Davis’ Violence Prevention Research Program designed to support health care providers in reducing firearm injury and death. This initiative brings together a growing network of health care providers looking for ways to reduce firearm injury and death, with particular emphasis on addressing firearm injury for populations at elevated risk.

**CONCLUSION**

Households with firearms are at increased risk of experiencing a homicide, suicide, or accidental firearm death of a household member. Despite clinical acceptance of the need for firearm injury prevention among high-risk populations, screening and counseling to increase safety is performed by only a minority of physicians. A need exists for physician training to increase physician confidence and self-efficacy toward counseling around firearm safety. While existing AMA policy encourages physicians to educate and counsel patients on firearm safety, it does not specifically address the issue of suicide. Given the prevalence of firearm suicides in the United States, physicians should be trained in lethal means safety counseling as a part of their suicide risk assessment and prevention efforts. Furthermore, laws in most jurisdictions do not provide the authority to remove firearms from a high-risk individual who already possesses them. The AMA should support common-sense laws allowing for the removal of firearms from individuals whose conduct indicates a heightened risk of violence to themselves or others.
RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted and the remainder of the report be filed.

1. That the following policy be adopted.

   Firearms and High-Risk Individuals
   Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders or convicted of misdemeanor domestic violence crimes, including dating partners, from possessing or purchasing firearms; (3) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (4) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (5) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (New HOD Policy)

2. That Policy H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” be amended by addition and deletion to read as follows:

   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. 3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide. (Modify Current HOD Policy)
   Teams,” H-145.990, “Prevention of Firearm Accidents in Children,” and H-145.997
   “Firearms as a Public Health Problem in the United States - Injuries and Death” be
   reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $1,000
REFERENCES

8. FL HB 155 (2011)
10. Minn. Stat. §144.05


REPORT 5 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-18)
Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking (Resolution 403-A-17)
(Reference Committee D)

EXECUTIVE SUMMARY

Objective: This report examines the available evidence regarding harm reduction approaches to reducing tobacco-related mortality, with a focus on electronic cigarettes.

Methods: English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from March 2014 to January 2018 using the search terms “tobacco” and “harm reduction,” “nicotine,” “electronic cigarette,” “e-cigarette,” “ENDS,” “noncombustible tobacco product,” “smokeless tobacco,” and “tobacco cessation.” Additional articles were identified by manual review of the reference lists of pertinent publications. Recognizing the dynamic nature of the research being published on this topic, the Council deemed it appropriate to summarize the findings and conclusions of the recent National Academies of Sciences, Engineering, and Medicine (National Academies) report on the “Public Health Consequences of E-Cigarettes” related to harm reduction. Articles published subsequent to the National Academies report are cited, as appropriate.

Results: Despite reductions in combustible tobacco use, it still represents the leading cause of preventable death in the United States. A growing number of non-combustible tobacco products are thought to be less hazardous than combustibles, but limited evidence is available on their long-term health risks. E-cigarettes are among the most widely used non-combustible tobacco product. Available evidence suggests that those who completely substitute e-cigarettes for combustible tobacco cigarettes have reduced exposure to numerous toxicants and carcinogens present in combustible tobacco cigarettes. However, the efficacy of e-cigarettes in reducing health risks has not been adequately evaluated in well-designed epidemiological studies and RCTs. Benefits are not realized in dual users, who in fact may be exposed to additional adverse health effects.

Conclusion: Currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless. Significant concerns exist that novel, non-combustible products may pose a significant threat to tobacco cessation and prevention efforts. Smokers concerned about their health who see the claims for novel tobacco products may think that a safer cigarette genuinely exists, making them less inclined to try to quit smoking. Likewise, those who never used tobacco products may initiate tobacco use assuming that a safe tobacco product exists. E-cigarette use among youth and young adults is a public health concern. Available data suggest that youth who use e-cigarettes are more likely to smoke combustible cigarettes. AMA policy should recognize that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction. Evidence-based methods for tobacco cessation exist. More needs to be done to promote evidence-based cessation methods to those who are trying to quit smoking.
INTRODUCTION

Resolution 403-A-17, “Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking,” introduced by the Resident and Fellow Section and referred by the House of Delegates, asks:

That our American Medical Association (AMA) advocate for tobacco harm reduction approaches to be added to existing tobacco treatment and control efforts (New HOD Policy);

That our AMA educate physicians and patients on the myriad health effects of different nicotine products and emphasize the critical role of smoke and combustion in causing disease (Directive to Take Action);

That our AMA encourage physicians to adopt patient-specific, individualized approaches to smoking cessation, particularly for patients with disease secondary to smoking and for patients who have otherwise failed traditional methods for smoking cessation (New HOD Policy);

That our AMA continue its focus on research to identify and expand options that may assist patients to transition away from smoking, including nicotine replacement therapies and noncombustible nicotine products (including e-cigarettes) (Directive to Take Action);

That the AMA reaffirm its position on strong enforcement of US Food and Drug Administration and other agency regulations for the prevention of use of all electronic nicotine delivery systems and tobacco products by anyone under the legal minimum purchase age. This shall include marketing to children, direct use or purchasing by children and indirect diversion to children. Further, that our AMA reaffirm physician education of patients to limit these products for children in any and all capacity. (Reaffirm HOD Policy)

The Council on Science and Public Health (Council) has issued two previous reports on electronic cigarettes, in 2010 and 2014, which helped establish our AMA’s existing policy around non-combustible tobacco products.
METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from March 2014 to January 2018 using the search terms “tobacco” and “harm reduction,” “nicotine,” “electronic cigarette,” “e-cigarette,” “ENDS,” “noncombustible tobacco product,” “smokeless tobacco,” and “tobacco cessation.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations also were reviewed for relevant information.

Recognizing the dynamic nature of the research being published on this topic, the Council deemed it appropriate to summarize the findings and conclusions of the recent National Academies of Sciences, Engineering, and Medicine (National Academies) report on the “Public Health Consequences of E-Cigarettes” related to harm reduction. Articles published subsequent to the National Academies report are cited, as appropriate, in this report.

CURRENT AMA POLICY

It is the AMA’s position that all tobacco products are harmful to health, and that there is no such thing as a safe cigarette. AMA policy urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA to have broad-based powers to regulate tobacco products. AMA policy also encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including the elimination of nicotine and elimination of additives that enhance addictiveness.

AMA policy encourages physicians to use evidence-based clinical practice guidelines on smoking cessation for the treatment of patients with nicotine dependence and urges physicians to promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers. Physicians should be prepared to counsel patients about the use of electronic nicotine delivery systems (ENDS), including electronic cigarettes (e-cigarettes), the potential for nicotine addiction, and the hazards of dual use of e-cigarettes with conventional cigarettes. Our AMA also encourages further clinical and epidemiological research on e-cigarettes as well as research and evaluation on promising smoking cessation protocols that promote abrupt cessation of smoking without reliance on pharmaceutical products.

HISTORY OF TOBACCO HARM REDUCTION

Tobacco products in any form are harmful and addictive and can cause disease and death. Combustible cigarettes cause the majority of tobacco-related disease and are responsible for more than 480,000 deaths in the United States each year, and for millions more living with smoking-related diseases. When used as intended, combustible cigarettes are addictive by design and are directly responsible for the deaths of at least half of all long-term users.

Over the last decade, a new generation of tobacco products has entered the marketplace promising reduced exposure to toxicants in tobacco smoke and claiming to reduce the risk of cancer or other diseases. This has resulted in a renewed discussion around harm reduction policies, which aim to reduce, but not eliminate tobacco-related health risks.

Public health advocates have been hesitant to support harm reduction approaches for tobacco because of a lack of trust in tobacco companies and their ability or willingness to develop products that will actually reduce risks. Several times in the last 50 years, the tobacco industry has...
developed a new cigarette, which it has promoted as safer. Large proportions of the smoking
population switched to these products, mistakenly believing they were reducing their health risk,
only to realize these were false promises. Specifically, experience with products promoted by the
tobacco industry as safer in the past, such as “light” cigarettes, resulted in increased toxicant
exposures with smokers compensating for reduced nicotine by smoking with greater frequency and
intensity.

In 2001, the Institute of Medicine (IOM, now the National Academies) assessed the science base
for tobacco harm reduction. The IOM committee concluded that for many diseases attributable to
tobacco use, reducing the risk of disease by reducing exposure to tobacco toxicants is feasible. However, such products have not been evaluated adequately to conclude they are in fact associated
with reduced risks. Furthermore, according to the IOM, “the regulation of all tobacco products is a
necessary precondition for assuring a scientific basis for determining the effects of potentially
reduced-exposure products and assuring the public has current, reliable information on the risks
and benefits.” Finally, the public health impact of potential reduced-exposure products is unknown
because their effect on public health will depend on their biological harm and individual and
community behaviors around their use.

In 2005, with funding from the American Legacy Foundation and the Robert Wood Johnson
Foundation, the Strategic Dialogue on Tobacco Harm Reduction (Dialogue) was formed to address
critically important aspects of the harm reduction debate including research priorities, overarching
strategic considerations, policy recommendations, and communication methods. Members of the
Dialogue agreed on the concept of the continuum of risk, which is determined by the delivery of
toxicants and nicotine. Nicotine replacement therapy (NRT) (i.e., “gum,” patch, and lozenge) is
on the safer end, with combustible cigarettes on the more hazardous end, of the spectrum. When
users of combustible cigarettes switch to smokeless tobacco products, “maximal potential reduction
in harm could only occur with products that result in the lowest exposure to toxicants, are subject
to government regulation, and that avoid adverse consequences such as increased initiation of
tobacco use or decreased cessation.”

THE CONTINUUM OF RISK

There is a spectrum of tobacco and medicinal products that are designed to deliver nicotine to the
user. The toxicity associated with these products varies.

FDA Approved Products for Treatment of Tobacco Use Disorder

FDA has approved several smoking cessation products designed to help users gradually withdraw
from smoking by using specific amounts of nicotine that decrease over time. NRT products are safe
and effective medications to help people stop smoking. While NRT products contain nicotine in
controlled amounts, they do not contain the other harmful chemicals found in tobacco products.
NRT products are available over the counter and by prescription. Over-the-counter NRTs are
approved for sale to people age 18 and older. They are available under various brand names
(sometimes as generic products) and include transdermal nicotine patches, nicotine gum, and
nicotine lozenges. Prescription NRT is available under the brand name Nicotrol, and is available
both as a nasal spray and an oral inhaler. The FDA has approved two pharmacotherapy products
for tobacco use disorder that do not contain nicotine. They are Chantix® (varenicline tartrate) and
Zyban® (buproprion hydrochloride). Both are available in tablet form and by prescription only.
Modified Risk Tobacco Product (MRTP)

MRTPs are tobacco products that are sold or distributed for use to reduce harm or the risk of tobacco-related disease associated with commercially marketed tobacco products.\textsuperscript{12} FDA can issue an order authorizing the marketing of a MRTP if the evidence demonstrates that the product will or is expected to benefit the health of the population.\textsuperscript{12}

The FDA has not approved any MRTPs. Applications from R.J. Reynolds Tobacco Company for their Camel Snus smokeless tobacco product and Philip Morris Products for their IQOS system with Marlboro Heatsticks (a heat not burn tobacco device) are currently under scientific review.\textsuperscript{12}

In January 2018, the FDA’s Tobacco Products Scientific Advisory Committee (TPSAC) voted 8-0 with one abstention against Philip Morris’ claim that the IQOS system can reduce the risks of tobacco-related diseases.\textsuperscript{13} In considering whether switching completely to IQOS presents less risk of harm than continuing to smoke cigarettes, the committee voted narrowly against the claim.\textsuperscript{13} TPSAC’s recommendations and votes are not binding on the FDA.

Non-Combustible Tobacco Products

A number of non-combustible tobacco products are promoted as less harmful than combustible cigarettes. However, limited data are available on the long-term health effects of these products. E-cigarettes are among the most popular of these products. In 2014, more than 460 brands of e-cigarettes, available in >7,700 unique flavors, were being sold on the internet.\textsuperscript{14} E-cigarette liquids can expose users to toxicants, including solvents (propylene glycol and glycerol), flavorings, and other additives. Furthermore, heating and aerosolizing e-liquids can generate additional harmful substances.\textsuperscript{2} The FDA currently regulates smokeless tobacco and some dissolvable tobacco products. The agency has finalized a rule extending its regulatory authority to all tobacco products, including e-cigarettes, cigars, hookah, and pipe tobacco, but recently extended the deadline for agency review.

Combustible Cigarettes

There are approximately 600 known ingredients in combustible cigarettes.\textsuperscript{15} When burned, more than 7,000 additional chemicals are created, at least 69 of which are known to cause cancer, and many others are poisonous.\textsuperscript{15} Smoking leads to disease and disability and harms nearly every organ of the body. For every person who dies because of smoking, at least 30 people live with a serious smoking-related illness.\textsuperscript{16} Smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease, including emphysema and chronic bronchitis.\textsuperscript{16} Secondhand smoke exposure contributes to approximately 41,000 deaths among non-smoking adults and 400 infant deaths annually.\textsuperscript{16} Secondhand smoke causes stroke, lung cancer, and coronary heart disease in adults.\textsuperscript{16} Infants and children who are exposed to secondhand smoke are at increased risk for sudden infant death syndrome, acute respiratory infections, middle ear disease, more severe asthma, respiratory symptoms, and slowed lung growth.\textsuperscript{16}

FDA PLAN FOR TOBACCO AND NICOTINE REGULATION

In 2017, the FDA announced plans to reduce the devastating toll of tobacco use. The plan involves two primary parts: (1) reducing the addictiveness of combustible cigarettes and (2) recognizing and clarifying the role that potentially less harmful tobacco products could play in improving public health.\textsuperscript{2} The FDA also has acknowledged the need for medicinal nicotine and other therapeutic products to play a greater role in helping smokers to quit and remain nonsmokers.\textsuperscript{2}
The Family Smoking Prevention and Tobacco Control Act of 2009 gave the FDA the authority to establish tobacco product standards that are appropriate for the protection of the public’s health. Standards may require the reduction or elimination of an additive, constituent, or other component of a tobacco product because it is or may be harmful. In March 2018, the FDA issued two advance notices of proposed rulemaking, one to explore a product standard to lower nicotine in cigarettes to minimally or non-addictive levels and the other calling on stakeholders to share data, research, and information to inform the role that flavors play in initiation, use, and cessation of tobacco products.

Reducing cigarettes’ addictiveness could potentially help addicted users quit more easily and help keep those who are experimenting from becoming regular smokers. While the FDA’s current plan does not include lowering nicotine levels in non-combustible tobacco products, conceptually the availability of potentially less harmful tobacco products could reduce risk while delivering levels of nicotine for adults who still want it.

E-CIGARETTES AND HARM REDUCTION

In January 2018, the National Academies issued a report on the “Public Health Consequences of E-cigarettes.” The report committee undertook a comprehensive review of the scientific literature regarding key constituents in e-cigarettes, human health effects, initiation and cessation of combustible tobacco cigarette use, and harm reduction.

In addressing harm reduction, the National Academies noted the absence of randomized controlled trials and longitudinal observational studies on the effects of switching from combustible tobacco cigarettes to e-cigarettes to reduce harm. Therefore, they relied on evidence regarding the exposure to toxicants present in e-cigarette aerosols compared with those in cigarette smoke, nicotine and toxicant exposures in e-cigarette users as an intermediate outcome, and comparisons of health effects on any health outcome from e-cigarette use compared with combustible tobacco cigarette smoking.

Based on a limited number of laboratory studies comparing emissions of harmful and potentially harmful chemicals from e-cigarette devices with those from combustible tobacco cigarettes, aerosol emitted from e-cigarettes is substantially less complex than tobacco smoke. Several potentially toxic substances have been identified in e-cigarette aerosol, but at significantly lower levels than in combustible tobacco smoke. The National Academies found that “there is conclusive evidence that completely substituting e-cigarettes for combustible tobacco cigarettes reduces users’ exposure to numerous toxicants and carcinogens present in combustible tobacco cigarettes.”

While the health effects of using e-cigarettes are not well understood, current evidence points to e-cigarettes being less harmful than combustible tobacco cigarettes. All but one of the studies reviewed by the National Academies showed significant short-term improvements in health outcomes in smokers who switched from combustible tobacco cigarettes to e-cigarettes. Thus, they concluded that “there is substantial evidence that completely switching from regular use of combustible tobacco cigarettes to e-cigarettes results in reduced short-term adverse health outcomes in several organ systems.”

Dual use of tobacco cigarettes and e-cigarettes is highly prevalent among adults and youth but little evidence exists about dual users’ patterns of use. On dual use, the National Academies concluded that, “there is no available evidence whether or not long-term e-cigarette use among smokers (dual use) changes morbidity or mortality compared with those who only smoke combustible tobacco cigarettes” and “there is insufficient evidence that e-cigarette use changes short-term adverse health
outcomes in several organ systems in smokers who continue to smoke combustible tobacco
cigarettes (dual users).”

No long-term studies exist comparing the health effects resulting from passive exposure to
secondhand aerosol from e-cigarettes with effects in non-smokers passively exposed to tobacco
smoke. A limited number of studies compared secondhand exposure to e-cigarette emissions to
combustible tobacco cigarette smoke. While e-cigarette use in indoor environments exposes non-
users to nicotine and particulates, it is at lower levels compared to tobacco smoke from
combustible cigarettes. The National Academies concluded that, “there is moderate evidence that
secondhand exposure to nicotine and particulates is lower from e-cigarettes compared with
combustible tobacco cigarettes.”

CURRENT USE PATTERNS

In 2013 and 2014, more than a quarter (27.6 percent) of adults were current users of at least one
type of tobacco product. A total of 8.9 percent of youths had used a tobacco product in the
previous 30 days and 1.6 percent of youths were daily users. Approximately 40 percent of tobacco
users used multiple tobacco products, with cigarettes plus e-cigarettes as the most common
combination. Although consumption of combustible tobacco products has decreased, the
consumption of non-cigarette combustible tobacco and smokeless tobacco has increased.

In 2014, 12.6 percent of adults had ever tried an e-cigarette (at least one time) and 3.7 percent of
adults currently used e-cigarettes. In 2016, 20.2 percent of surveyed high school students and 7.2
percent of middle school students reported current tobacco product use. E-cigarettes are the most
commonly used tobacco product among high (11.3 percent) and middle (4.3 percent) school
students. In 2018, health officials raised concerns about Juul, a brand of e-cigarette that looks like
a flash drive. The devices are difficult to distinguish from a real flash drive and their vapor
dissipates quickly making them easy to hide. Each Juul cartridge lasts about 200 puffs and has as
much nicotine as an entire pack of cigarettes. “Juuling” has become widespread enough that school
districts in several states have voiced concerns and, in some cases, have amended school policy to
address the issue.

Use of e-cigarettes, hookah, non-cigarette combustible tobacco, or smokeless tobacco by youth is
associated with cigarette smoking one year later. Furthermore, the risk of progressing to
conventional cigarette smoking is increased with use of multiple forms of non-cigarette tobacco,
suggesting that novel tobacco products have the potential to undermine public health gains in
combatting the smoking epidemic. Among adolescent cigarette experimenters, using e-cigarettes
has been positively and independently associated with progression to current established smoking,
suggesting that e-cigarettes may encourage cigarette smoking in this population. E-cigarette use
among youth and young adults is a public health concern, and coordinated efforts are needed to
protect young people from a lifetime of nicotine addiction.

SMOKING CESSATION

The United States Preventive Services Task Force (USPSTF) recommends that clinicians ask all
adults about tobacco use, advise them to stop using tobacco, provide behavioral interventions and
offer FDA-approved pharmacotherapy for cessation to adults who use tobacco. In 2015, 68
percent of adults smokers wanted to quit smoking, 57 percent had been advised by a health
professional to quit, and 31 percent had used cessation counseling and/or medications when trying
to quit. Fewer than one-third of persons used evidenced-based cessation methods when trying to
quit smoking.\textsuperscript{28} To enhance cessation rates, health care providers should consistently identify smokers, advise them to quit, and promote the use of evidenced-based cessation treatments.\textsuperscript{28}

The USPSTF also examined the evidence on the use of e-cigarettes or ENDS and concluded that the current evidence is insufficient to recommend ENDS for tobacco cessation in adults, including pregnant women.\textsuperscript{27} Furthermore, a large prospective study of recently hospitalized smokers (\textit{n}=1357) who planned to quit found a negative association between the use of e-cigarettes after discharge and subsequent tobacco abstinence.\textsuperscript{29} Not only does the intermittent and concurrent use of e-cigarettes with other cessation aids not aid quitting, it may hamper it.\textsuperscript{29} The USPSTF recommends that clinicians direct patients who smoke tobacco to cessation interventions with established effectiveness and safety.\textsuperscript{27}

CONCLUSION

Despite reductions in combustible tobacco use, it still represents the leading cause of preventable death in the United States. A growing number of non-combustible tobacco products are thought to be less hazardous than combustibles, but limited evidence is available on their long-term health risks. The FDA has the authority to designate products as MRTP, but to date, no products have met the criteria and been approved through this pathway.

E-cigarettes are among the most widely used non-combustible tobacco products. Available evidence suggests that those who completely substitute e-cigarettes for combustible tobacco cigarettes have reduced exposure to numerous toxicants and carcinogens present in combustible tobacco cigarettes, resulting in reduced short-term adverse health outcomes in several organ systems. However, long-term studies on the health effects of e-cigarettes are lacking. Furthermore, the efficacy of e-cigarettes in reducing health risks has not been adequately evaluated in well-designed epidemiological studies and RCTs. Benefits are not realized in dual users, who in fact may be exposed to additional adverse health effects.

Significant concerns exist that novel, non-combustible products may pose a significant threat to tobacco cessation and prevention efforts. Smokers concerned about their health who see the claims for novel tobacco products may think that a safer cigarette genuinely exists, making them less inclined to try to quit smoking. Furthermore, ex-smokers may start smoking again, thinking they can now safely consume tobacco products. Likewise, those who never used tobacco products may initiate tobacco use assuming that a safe tobacco product exists. E-cigarette use among youth and young adults is a public health concern. Available data suggest that youth who use e-cigarettes are more likely to smoke combustible cigarettes.

Evidence-based methods for tobacco cessation exist. The FDA has approved several smoking cessation products designed to help users gradually withdraw from smoking by using specific amounts of nicotine that decrease over time. The USPSTF has reviewed the evidence and recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, provide behavioral interventions, and offer FDA approved pharmacotherapy for cessation to adults who use tobacco. More needs to be done to promote evidence-based cessation methods to those who are trying to quit smoking.

RECOMMENDATIONS

The Council recommends that the following statements be adopted in lieu of Resolution 403-A-17, and the remainder of the report be filed.
1. That Policy H-495.988, “FDA Regulation of Tobacco Products,” be amended by addition and deletion to read as follows:

H-495.988 FDA Regulation of Tobacco Products
1. Our AMA: (A) reaffirms its position acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and is associated with the use of combustible tobacco cigarettes in youth; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (DB) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (EC) reaffirms its position that the Food and Drug Administration (FDA) does have, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (FD) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (GE) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (HF) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (IG) strongly opposes legislation which would undermine the FDA’s authority to regulate tobacco products… (Amend Current HOD Policy)

2. That Policy H-495.972, “Electronic Cigarettes, Vaping, and Health: 2014 Update,” be amended by addition and deletion to read as follows, with a change in title:

Electronic Cigarettes, Vaping, and Health: 2014 Update
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; 3. Our AMA (b) supports education of the public on electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction. (Amend Current HOD Policy)

3. That Policy H-495.973, “FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products,” be amended by addition and deletion to read as follows:
H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth. (Amend Current HOD Policy)

4. That Policy, H-490.917, “Physician Responsibilities for Tobacco Cessation” be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: less than $500
REFERENCES

Whereas, Advances in LED light emitting diode, xenon gas and incandescent illumination is producing brighter vehicular headlights; and

Whereas, The field of illumination can be altered in intensity of brightness, and shape and size; and

Whereas, Different tints and shades of light have also been used; and

Whereas, Better vehicular lights can enhance the safety of driving at night when no other vehicles are present; and

Whereas, The average age of the U.S. population is increasing with greater difficulty with vision at night consisting of glare and transient blindness when faced with a bright vehicular light at night; and

Whereas, The danger is increased for both drivers and their passengers if one or both have impaired vision due to glare or blindness from the bright lights of an approaching vehicle; and

Whereas, High beam lights can be especially bright and therefore dangerous when drivers fail to lower the beam for approaching vehicles; and

Whereas, Multiple state legislatures have been studying this issue and in some cases passing legislation to regulate the headlights; and

Whereas, The AMA has studied the health consequences of artificial light; and

Whereas, The Council on Science and Public Health might provide insight to our AMA by studying this issue; therefore be it

RESOLVED, That our American Medical Association study the danger of bright vehicle headlights and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA study the safety risks to drivers and their passengers when they approach vehicles with incandescent, xenon gas or LED headlights, as well as the use of other technologies such as automated steering and automated windshield tinting to mitigate the risk (Directive to Take Action); and be it further
RESOLVED, That our AMA advocate for mandatory automated high-beam to low-beam headlight switching systems that would operate when an approaching vehicle headlight is detected. (Directive to Take Action)

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

Received: 02/12/18
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-18)

Introduced by: American Academy of Pediatrics

Subject: Schools as Gun-Free Zones

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Escalating violence and shootings are rampant such that as of the writing of this resolution, this is the eighteenth school shooting in 2018, the equivalent of one every two and a half days so far this year; and

Whereas, The President of the United States has proposed bonuses for teachers to undergo gun training for concealed weapons; and

Whereas, The job of a teacher is to educate their students, not to shoot potential armed assailants; and

Whereas, Randi Weingarten, head of the American Federation of Teachers, criticized the proposal in a statement on behalf of the teachers’ union, "Teachers don’t want to be armed," Weingarten said. "We want to teach. We don’t want to be, and would never have the expertise needed to be, sharp shooters; no amount of training can prepare an armed teacher to go up against an AR-15."; and

Whereas, Arming teachers runs counter to existing AMA policy on guns in the school setting, school violence, training teachers to identify potentially dangerous children, increasing mental illness detection, and violence-reduction criteria that encourage states to ensure that schools are safe harbors, secure from weapons, and staffed with educators trained in violence mitigation (H-60.947, H-145.983, H-60.946, D-345.994, H-60.943); therefore be it

RESOLVED, That our American Medical Association advocate for schools to remain gun-free zones (New HOD Policy); and be it further

RESOLVED, That our AMA oppose requirements or incentives of teachers to carry weapons. (New HOD Policy)

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

Received: 04/19/18

RELEVANT AMA POLICY

Guns in School Settings H-60.947 - Our AMA recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment. Res. 402, l-98 Reaffirmed: CSAPH Rep. 2, A-08
Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997 - Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level. CSA Rep. A, I-87 Reaffirmed: BOT Rep. I-93-50 Appended: Res. 403, I-99 Reaffirmation A-07 Reaffirmation A-13 Appended: Res. 921, I-13

Gun Violence as a Public Health Crisis D-145.995 - Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban. Res. 1011, A-16

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975 - 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


Need for Adequate Training of Teachers to Identify Potentially Dangerous Children and the Provision of Adequate Insurance Coverage to Provide for their Treatment H-60.946 - Our AMA: (1) supports teacher education initiatives to better enable them to identify children at risk for psychiatric illnesses, substance abuse, and potentially dangerous behaviors; and (2) reaffirms its support for parity of coverage for mental illness. Sub. Res. 118, A-99 Reaffirmed: CSAPH Rep. 1, A-09

See also: Increasing Detection of Mental Illness and Encouraging Education D-345.994; Bullying Behaviors Among Children and Adolescents H-60.943
Whereas, Many children, adolescents, and adults have died from firearm injury in schools; and
Whereas, The perpetrators of school-based firearm violence are usually students, former students, or young adults with mental illness; and
Whereas, Twenty percent of children, adolescents, and young adults have diagnosable mental health disorders; and
Whereas, Only 20% of children, adolescents, and young adults with mental health disorders receive mental health services; and
Whereas, There are community-based models through which students can undergo mental health screenings and receive mental health services as indicated on-site at school; and
Whereas, Schools can employ sufficient nurses and mental health clinical social workers to address the mental health problems of students; and
Whereas, Schools can contract with mental health professionals who partner with the schools to implement school-based comprehensive mental health programs for students; and
Whereas, The schools can develop telehealth mental health screening and therapy programs for students in partnership with primary care and mental health professionals; therefore be it
RESOLVED, That our American Medical Association promote the implementation of school-based mental health screening and therapy programs within its efforts to reduce school-based firearm violence. (New HOD Policy)

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

Received: 04/19/18
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-18)

Introduced by: Medical Student Section

Subject: Emphasizing the Human Papillomavirus Vaccines as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, About 14 million Americans are newly infected with human papillomavirus (HPV) each year;1 and

Whereas, Subclinical HPV infection may be as high as 40%, which can further exacerbate the spread of HPV as these asymptomatic individuals may unknowingly infect others with the virus;1,2,3,4,5,6,7 and

Whereas, Approximately 19,200 women and 11,600 men in the US are diagnosed with an HPV-caused cancer or dysplasia;3,8,9,10 and

Whereas, From 2008-2012, HPV-related cancers climbed to 39,000 and of these cases, 28,500 were preventable with the currently available 9-valent HPV vaccine;3,5 and

Whereas, Despite Centers for Disease Control and Prevention (CDC) supporting vaccination of boys and girls, US vaccination rates are still low at only 49.5% for girls and 37.5% for boys;3,11 and

Whereas, Data demonstrates that a primary reason for poor vaccination rates despite health care coverage and CDC support has been the lack of a strong recommendation by providers;6,10,12,13 and


Whereas, The association of HPV vaccination as anti-STI instead of anti-cancer has created public misconceptions, leading to low vaccination rates despite a recent cohort study revealing no association between HPV vaccination and sexual-activity-related outcomes;\(^4\) and

Whereas, Rates of HPV related cervical dysplasia have decreased in the age groups who had HPV vaccination available to them, while those in age groups beyond the recommended vaccination age have stayed stagnant;\(^5\) and

Whereas, Research shows that health care provider (HCP) recommendation correlates strongly with HPV vaccination in females, whilst existing structural barriers as well as perceived low cost-effectiveness has prevented HCP recommendations for males;\(^14,15\) and

Whereas, Head and neck cancer is the sixth most common cancer worldwide and its ever-increasing incidence is linked to HPV infection;\(^16\) and

Whereas, Current oropharyngeal cancer screening is underdeveloped and uncommon, contributing to the need for increased emphasis of the HPV vaccine as a preventative measure;\(^9\) and

Whereas, Oropharyngeal cancer is more common in males than females; men who received the HPV vaccine had increased levels of both circulating and oral HPV antibodies which may lead to a decrease in the incidence of oropharyngeal cancer;\(^17\) therefore be it

RESOLVED, That our American Medical Association acknowledge HPV vaccines as beneficial to all genders as anti-cancer and anti-STI (New HOD Policy); and be it further

RESOLVED, That our AMA support appropriate stakeholders to increase public awareness of HPV vaccines effectiveness against both HPV-related cancers and STIs. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Date received: 04/26/18

RELEVANT AMA POLICY:
HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872
Human Papillomavirus (HPV) Inclusion in High School Education Curricula D-170.995
Insurance Coverage for HPV Vaccine D-440.955


Whereas, Health disparities persist among African American and other ethnic and racial minorities across and despite socioeconomic status (SES), and racial housing segregation is a structural source and amplifier of these racial health disparities;1,2 and

Whereas, Numerous epidemiologic studies have demonstrated that segregated African American, Hispanic, and other ethnic and racial minority communities face increased rates of infant mortality, obesity, hypertension, asthma, lung cancer, mental health stressors, and psychiatric disorders, among other environmentally-associated adverse health outcomes;3,4,5,6,7 and

Whereas, The Institute of Medicine, now known as the National Academy of Medicine, has acknowledged that communities of color are disproportionately exposed to environmental burdens and hazards affecting health, including but not limited to lead, air pollutants, and toxic waste due to where they live, and has advocated for the linking of data on environmental health outcomes to data on affected communities;8 and

Whereas, Even when controlling for socio-economic status, racially-segregated minority neighborhoods have a disproportionate share of liquor stores and fast food outlets and a dearth of grocery stores and recreational facilities, leading to increased rates of diabetes, hypertension, and heart disease;2,9,10 and

Whereas, The AMA has recognized that public education disparities, which fall along racial and economic lines, are a detriment to health (H-60.917), representing a public health and civil rights issue, and research establishes that such disparities are largely due to housing segregation;1,2 and

Whereas, Despite the passage of the 1968 Fair Housing Act to end discriminatory housing practices that perpetuate race-based segregation, de facto racial housing segregation continues

---

in the form of restrictive zoning favoring low-density development and excluding multi-family housing, predatory loan practices, and the discouragement of people of color or low SES by real estate agents and landlords away from neighborhoods that are majority-white;\textsuperscript{11,12,13} and

Whereas, As of 2010, a third of all metropolitan African Americans continued to live under conditions of housing hypersegregation and as of 2017, racial and ethnic gaps continue to exist in homeownership and housing wealth when comparing African Americans and Hispanics with whites;\textsuperscript{14}

Whereas, Geographic Information Systems (GIS) data, which can be used to co-locate demographic and mapping data, including housing segregation, with health outcomes has been a critical tool for public health researchers to elucidate and act on health disparities, most notably mapping the Flint water crisis and the disproportionate impact of lead exposure on African American neighborhoods;\textsuperscript{6,15,16}

Whereas, The Affirmatively Furthering Fair Housing (AFFH) GIS platform was created in 2015 by the Department of Housing and Urban Development (HUD) Office of Fair Housing and Equal Opportunity to monitor the progress of the 1968 Fair Housing Act, collect and make publicly accessible data on ongoing racial and economic segregation in communities, and examine the disparities in access to education and employment opportunities, and has been lauded by the American Public Health Association as a critical tool in advancing desegregation and improving health outcomes in minority communities;\textsuperscript{17,18}

Whereas, There is a proposed $8.8 billion (18.3\%) cut to the HUD budget for the 2019 fiscal year;\textsuperscript{19}

Whereas, There is pending legislation to bar any federal funds to be used “to design, build maintain, utilize or provide access to a federal database of geospatial information on community racial disparities OR disparities in access to affordable housing”;\textsuperscript{20,21} therefore be it

RESOLVED, That our American Medical Association oppose policies that enable racial housing segregation (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool. (New HOD Policy)

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

Received: 04/27/18


\textsuperscript{13} U.S. Department of Housing and Urban Development. HOUSING DISCRIMINATION AGAINST RACIAL AND ETHNIC MINORITIES 2012 Executive Summary. 2013.

\textsuperscript{14} Stanford Center on Poverty and Inequality, State of the Union 2017. 2017.


\textsuperscript{17} Smedley BD, Tegeler P. "Affirmatively Furthering Fair Housing": A Platform for Public Health Advocates. American Journal of Public Health. 106, no. 6 (June 1, 2016): pp. 1013-1014.

\textsuperscript{18} "AFFH Fact Sheet: The Duty to Affirmatively Further Fair Housing, HUD." https://www.huduser.gov/portal/sites/default/files/pdf/AFFH-Fact-Sheet.pdf


\textsuperscript{20} H.R.482. Local Zoning Decisions Protection Act of 2017. 115th Congress.

\textsuperscript{21} S.103. Local Zoning Decisions Protection Act of 2017. 115th Congress.
Whereas, More than 60% of children and adolescents across different demographics have reported to being victim or witness to a form of violence;¹ and

Whereas, Childhood exposure to violence has been linked to negative long-term consequences, such as future commitment of violence, symptoms of trauma, feelings of helplessness, and negative school performance;²,³,⁴,⁵,⁶ and

Whereas, As of 2010, the cost of violence in the United States was estimated to be at least $460 billion;⁷ and

Whereas, WHO reports have shown that intervention programs based on public health models for early childhood, parenting, and family therapies correlate to a long-term decrease in violent behaviors;⁵ and

Whereas, Cities that have implemented effective and evidence-based public health violence prevention models, such as the Cure Violence model, have seen a significant drop in violent acts, most notably showing an 80%-100% reduction in retaliation attacks;⁸,⁹ and

Whereas, The CDC has endorsed an evidence-based, four-step public health approach to violence prevention;¹⁰ and

⁸ Dicker, R. Hospital-Based Violence Intervention: an Emerging Practice Based on Public Health Principles. Trauma Surgery & Acute Care Open. 2017;1(1).
Whereas, The AMA supports “investment in primary prevention activities related to violence,” as well as in research and services that encourage physicians to get involved in violence prevention (AMA Policy H-515.964); and

Whereas, H.R.2757 Public Health Violence Prevention Act aims to fund public health violence prevention models through a grant based system;11 therefore be it

RESOLVED, That our American Medical Association support legislation in addition to other mechanisms that encourage the development and use of evidence-based public health models that prevent violence. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY:

Violence Activities H-515.964 - Our AMA: (1) endorses the Declaration of Washington, which urges national medical associations worldwide to promote an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for peaceful purposes; (2) specifically endorses the WHO's World Report on Violence and Health and recognizes the value of its global perspective on all forms of violence; and (3) supports investment in primary prevention activities related to violence as well as in research and services that encourage physicians to get involved in violence prevention (e.g., detect violence among patients, advocate for legislation), and encourages the development of curricula for teaching of violence prevention in schools of medicine. Citation: (BOT Rep. 9, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955 - 1. Our AMA encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities. 2. Our AMA affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health. 3. Our AMA encourages the Centers for Disease Control and Prevention as well as state and local health departments and agencies to research the nature and public health implications of violence involving law enforcement. Citation: Res. 406, A-16;

Violence and Abuse Prevention in the Health Care Workplace H-515.966 - Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees. Citation: Res. 424, I-98; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13; Modified: CSAPH Rep. 07, A-16;

See also: Family Violence-Adolescents as Victims and Perpetrators H-515.981; Health Care Costs of Violence and Abuse Across the Lifespan D-515.984; Public Health Policy Approach for Preventing Violence in America H-515.971

WHEREAS, The rate of Sudden Unexpected Infant Deaths (SUID) due to accidental strangulation or suffocation has been rising since 1997 to a peak of 23.1 deaths per 100,000 live births in 2015; totaling approximately 3,700, of which 25% were due to accidental strangulation or suffocation in bed;¹ ² and

WHEREAS, Infants younger than three months of age are significantly more likely to die of causes associated with bed-sharing than other sleep-associated suffocations such as lying prone on a blanket or stuffed animal;³ and

WHEREAS, The rate of bed-sharing from 1993 to 2010 has doubled, and bed-sharing increases the risk of infant death through suffocation;⁴ and

WHEREAS, Racial, socioeconomic, and geographic disparities exist in the rates of infant death, as black individuals display higher rates of bed-sharing and higher rates of infant death;³,⁴ and

WHEREAS, The American Academy of Pediatrics (AAP) recommends focusing on a safe sleep environment as the primary way to reduce the risk of all sleep-related infant deaths, including SUID;⁵ and

WHEREAS, The AAP recommends that infants sleep in the supine position and independently on an uncluttered flat surface and “in the parents’ room, close to the parents’ bed, but on a separate surface designed for infants, ideally for the first year of life, but at least for the first 6 months,”⁶,⁷ and

WHEREAS, Baby boxes⁸, typically equipped with educational materials on newborn care and newborn supplies such as clothing and diapers, are cardboard boxes with a firm mattress that are designed to meet the AAP’s description of a safe sleeping environment for infants;⁸ and

Whereas, New Jersey, Alabama, Ohio, Colorado, Texas, and Virginia have developed statewide baby box programs which include a baby box and postpartum supplies, free of charge, upon completion of a 20-minute caretaker educational program;\(^8\),\(^9\),\(^10\) and

Whereas, Unpublished data has shown that when provided the education, bed-sharing is decreased and mothers are more likely to use a baby box as a sleeping place for their infants;\(^11\) and

Whereas, The AAP stated concerns over a lack of safety research and "insufficient data on the role cardboard boxes play in reducing infant mortality;"\(^12\) therefore be it

RESOLVED, That our American Medical Association support the research of safe sleeping environment programs, which could include the study of the safety and efficacy of boxes for babies to sleep in as a potential initiative to decrease the incidence of Sudden Unexpected Infant Death in the United States. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY:

**Infant Mortality in the United States H-245.986** - It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients. Citation: BOT Rep. U, I-91; Modified by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Modified: CSAPH Rep. 01, A-17;

**Infant Mortality D-245.994** - 1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers. 2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.

Citation: (Res. 410, A-10)

See also: [Sudden Infant Death Syndrome H-245.977](https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Child-Death-Review/Pages/Safe-Sleep.aspx); [Infant Mortality Statistics H-245.998](https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Child-Death-Review/Pages/Safe-Sleep.aspx)
Whereas, More than two thirds of the 630,000 people currently in local jails are pretrial detainees, the majority of which are charged with nonviolent crimes and cannot afford to pay bail;¹ and

Whereas, Detainment in jail confers an increased risk for self harm and suicide, accounting for 35.3% of all jail deaths at a rate of 50 deaths per 100,000 people in 2014, compared to the general US population rate of 13 deaths per 100,000 people;²,³,⁴ and

Whereas, Infectious diseases such as tuberculosis, HIV/AIDS, hepatitis C, and common STDs are more prevalent in correctional facilities than the general US population, which increases the risk of transmission to both newly detained populations and the communities they re-enter upon release;⁵ and

Whereas, Sexual victimization was reported by 3.2% of jail inmates from 2011 to 2012, disproportionately affecting women in both staff-on-inmate and inmate-on-inmate victimizations;⁶,⁷ and

Whereas, Sixty-eight percent of people in jails have a substance use disorder, but less than 15% of those incarcerated receive appropriate treatment, increasing the likelihood of withdrawal while incarcerated as well as significantly increasing the likelihood of overdose upon release into the community;⁵,⁷ and

Whereas, Thirty-eight states in 2014 had policies to terminate Medicaid coverage when incarceration lasted for more than 30 days, leading to interruptions in coverage and healthcare;⁵ and

References:
Whereas, Incarceration separates families, leading to disruptions in education, employment, and housing, all of which can perpetuate cycles of poverty\(^5,8\) and

Whereas, Juvenile detention interrupts secondary education and has been shown to increase dropout rates after return to school\(^9,10\) and

Whereas, According to a study surveying formerly incarcerated people and their families in 14 different states, 49% of families were unable to meet basic food needs and 48% had trouble meeting basic housing needs while their loved one was incarcerated\(^11\) and

Whereas, Once detained, a defendant’s time awaiting trial can exceed 3 years depending on where he or she lives\(^10,12\) and

Whereas, Members of lower income communities and minorities are disproportionately detained, incarcerated, and subjected to the significant health risks outlined above because of their inability to pay bail, as 80% of those who cannot afford bail are in the poorest half of society\(^1\) and

Whereas, Alternatives to money bail such as unsecured bonds, in which a defendant promises to pay a dollar amount only if he or she fails to appear at trial, have been shown to achieve equal levels of public safety and court appearance while shielding the individual from the aforementioned health risks of pretrial detention\(^13\) therefore be it

RESOLVED, That our American Medical Association support legislation that ends pretrial financial release options for individuals charged with nonviolent crimes. (New HOD Policy)

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

Received: 04/27/18

RELEVANT AMA POLICY:

**AMA Support for Justice Reinvestment Initiatives H-95.931**

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Citation: Res. 205, A-16;

See also: [Health Care While Incarcerated H-430.986](#)

---


\(^{12}\) Faltering Courts, Mired in Delays. April 13 2013.

WHEREAS, Black and Latino youth exhibit disproportionately higher rates of overweight and obesity compared to their white counterparts;¹ and

WHEREAS, Black and Latino youth face higher risks for the severe, lifelong health consequences of poor diet and obesity, including cardiovascular disease, asthma, diabetes, and cancer;²,³,⁴,⁵ and

WHEREAS, It has been shown that Blacks and Latinos consume fast food and sugary drinks more often than non-Hispanic white youth;⁶,⁷ and

WHEREAS, Exposure to food advertising increases children's and teen's consumption of highly advertised fast food and sugary beverages, increases snacking, and increases total calories consumed;⁶,⁸,⁹,¹⁰ and

WHEREAS, The Institute of Medicine found that food marketing to children results in increased preferences for nutrition poor foods and increased requests to parents for similarly unhealthy foods;¹¹ and

WHEREAS, Children are unable to recognize the persuasive intent of advertising and are therefore unable to modify their interpretations of advertising messages;¹² and

Whereas, Reports have shown that Black and Latino youth experience double the amount of unhealthy food marketing compared with white non-Hispanic youth;\(^1\) and

Whereas, Companies market nutrition products to poor black and Latino youth at a rate that is disproportionately high when compared with white non-Hispanic youth;\(^{14,15}\) and

Whereas, Current AMA policy states that “Our AMA ... monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care.” (D-440.978); and

Whereas, Current AMA policy states that “It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children.” (H-60.972); therefore be it

RESOLVED, That our American Medical Association establish a formal position advocating against the use of targeted marketing of nutrient-poor food toward youth from vulnerable populations, including minority and low-income populations (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-60.972 by addition to read as follows:

(1) It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children; and

(2) The AMA will support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA toward youth from vulnerable populations; (Modify Current HOD Policy) and be it further

RESOLVED, That our AMA work with the appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward youth from vulnerable populations. (Directive to Take Action)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Banning Food Commercials Aimed at Children H-60.972
Culturally Responsive Dietary and Nutritional Guidelines D-440.978
Television Commercials Aimed at Children H-485.998
Alcohol and Youth D-170.998
Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths D-60.973


\(^{15}\) Harris JL, Schwartz MB, Brownell KD, Javadizadeh J, Weinberg M. Evaluating sugary drink nutrition and marketing to youth. New Haven, CT: Yale Rudd Center For Food Policy and Obesity. 2011.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-18)

Introduced by: Medical Student Section

Subject: Opposition to Measures that Criminalize Homelessness

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Homelessness results in decreased access to healthcare and higher hospitalization costs, and is an independent risk factor for increased mortality;1,2,3,4,5,6 and

Whereas, There is a trend in U.S. cities over the past few decades to target homeless persons living in public spaces, using the justice system to criminalize activities necessary for sustaining life;7,8 and

Whereas, The United Nations Human Rights Committee reports that “criminalization of people living on the street for everyday activities such as eating, sleeping, sitting in particular areas etc.” within U.S. cities “raises concerns of discrimination and cruel, inhuman, or degrading treatment” and that “the State party should engage with state and local authorities to abolish criminalization of homelessness laws and policies at state and local levels”9, and

Whereas, The Department of Justice has affirmed the constitutional rights of homeless individuals to sleep in public spaces, stating that it is “uncontroversial that punishing conduct that is a universal and unavoidable consequence of being human violates the Eighth Amendment”;10,11 and

---

8 Homes Not Handcuffs: The Criminalization of Homelessness in U.S. Cities. Published by the National Coalition for the Homeless and the National Law Center on Homelessness & Poverty, July 2009. United Nations Human Rights Committee, List of Issues to be Taken up in Connection
9 United Nations Human Rights Committee, List of Issues to be Taken up in Connection with the Consideration of the Fourth Periodic Report of the United States of America (CCPR/C/USA/4), Adopted by the Committee at its 110th Session, 10-28 March 2014 (advance unedited version).
10 The United States Department of Justice. Justice Department Files Brief to Address the Criminalization of Homelessness. http://www.justice.gov/opa/pr/justice-department-files-brief-address-criminalization-homelessness
Whereas, The ACLU has opposed several policies that target homeless individuals including regulations that prohibit sharing food outdoors with individuals in need, anti-panhandling ordinances, trespassing laws, and laws against encampment;\textsuperscript{12,13} and

Whereas, According to the National Coalition for the Homeless and the National Law Center on Homelessness & Poverty, types of criminalization measures against the homeless include, but are not limited to:

- Legislation that makes it illegal to sleep, sit, or store personal belongings in public spaces against homeless persons
- Selective enforcement of more neutral laws, such as loitering or open container laws, resulting in the destruction of those persons’ personal property, including important personal documents and medications
- Sweeps of city areas where homeless persons are living to drive them out of the area, punishment for begging or panhandling in order to move poor or homeless persons out of a city or downtown area\textsuperscript{14}; and

Whereas, Policies such as those listed by the National Coalition for the Homeless and the National Law Center on Homelessness & Poverty criminalize homelessness without addressing the underlying causes of homelessness and, through exacerbating the problem, lead to poorer health among homeless persons;\textsuperscript{8,9} and

Whereas, Criminalization of homelessness leading to arrest for life-sustaining activities advances the development of criminal records among the homeless population, making it more difficult to obtain employment and housing;\textsuperscript{8} and

Whereas, Criminalization of homelessness is not cost efficient; in a nine-city survey of supportive housing and jail costs, it was found that "jail costs were on average two to three times the cost of supportive housing"\textsuperscript{8,14} and

Whereas, Homeless persons often suffer from poor nutrition, yet many U.S. cities have criminalized the feeding of homeless persons by both private individuals and nonprofit organizations;\textsuperscript{8,12,15,16,17,18,19,20} and

Whereas, While homeless encampments reflect a temporary solution to the severe shortage of adequate affordable housing for the number of homeless persons in the U.S., forced evictions of people living in homeless encampments violates the human right to adequate housing;\textsuperscript{21,22} and

\textsuperscript{12} American Civil Liberties Union of Pennsylvania. City of Philadelphia Sued over New Regulations that Prevent Religious Groups from Providing Food for the Homeless in City Parks.
\textsuperscript{16} Dallas, Tx., Ordinance No. 26023 (2005).
\textsuperscript{17} Atlanta, Ga., Code of Ordinances ch. 43, § 1 2005.
\textsuperscript{18} Cleveland, Oh., Code § 605.31 2005.
\textsuperscript{20} Cincinnati, Oh., Code § 910-12. 2004.
\textsuperscript{21} Office of the United Nations High Commissioner for Human Rights. The Right to Adequate Housing. Fact Sheet No. 21 (Rev. 1). Signed by the United States of America.
Whereas, A number of U.S states including Rhode Island, Connecticut, and Illinois have passed Homeless Bills of Rights enumerating that all homeless persons have equal rights, including access to emergency medical care and free movement in public spaces without harassment or intimidation, regardless of housing status; therefore be it

RESOLVED, That our American Medical Association oppose measures that criminalize necessary means of living among homeless persons, including but not limited to, sitting or sleeping in public spaces (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; and (2) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.

Citation: (Res. 401, A-15)

The Mentally Ill Homeless H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16;

23 Rhode Island, Bill § S 2052 SUBSTITUTE B. 2012
24 Connecticut, Bill § S.B. No. 896. 2013
25 Illinois, Bill § S.B. No. 1210. 2013
Whereas, In the last five years, the incidence of military child abuse and neglect has risen from 4.8 per 1,000 to 7.2 per 1,000;¹ and

Whereas, Military families typically relocate often, making it difficult to track instances of child abuse and neglect strictly through state child protective services (CPS);² and

Whereas, The Family Advocacy Program (FAP) within the Department of Defense (DoD) assists in reports of child abuse and neglect in the military when the alleged victim(s) are under age eighteen and/or have a physical or mental incapacity, in addition to being in the legal care of a military personnel, military family member, or DoD sanctioned child care provider;³ and

Whereas, The FAP has over 2,000 counselors and specialized clinicians who work to prevent child abuse and neglect in military families through education and treatment of perpetrators and victims;⁵ and

Whereas, HR 3894 was passed in December 2016, requiring individuals of the Armed Forces, DoD employees, or contracted military employees to promptly report known or suspected cases of child abuse and neglect within a military installation to the DoD and state CPS;⁴ and

Whereas, There is currently no reciprocal requirement for state CPS to report known or suspected cases of child abuse and neglect to the FAP;⁵ and

Whereas, The probability of linkage between a military child abuse and neglect case and a FAP report is lower if the treatment occurred in a civilian facility (9.8% of abuse occurs in civilian facilities versus 23.6% at military facilities), suggesting decreased communication of military child abuse and neglect from the state to the FAP;⁶ and

Whereas, Fifteen states have enacted laws or enforced policies already in place that require
suspected cases of child abuse and neglect brought to CPS also be reported to the FAP;⁷ therefore be it

RESOLVED, That our American Medical Association support state and federal-run child
protective services in reporting child abuse and neglect in the military to the Family Advocacy
Program within the Department of Defense. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY

Identifying and Reporting Suspected Child Abuse H-515.960
1. Our American Medical Association recognizes that suspected child abuse is being
underreported by physicians.
2. Our AMA supports development of a comprehensive educational strategy across the
continuum of professional development that is designed to improve the detection, reporting, and
treatment of child maltreatment. Training should include specific knowledge about child
protective services policies, services, impact on families, and outcomes of intervention.
3. Our AMA supports the concept that physicians act as advocates for children, and as such,
have a responsibility legally and otherwise, to protect children when there is a suspicion of
abuse.
4. Our AMA recognizes the need for ongoing studies to better understand physicians failure to
recognize and report suspected child abuse.
5. Our AMA acknowledges that conflicts often exist between physicians and child protective
services, and that physicians and child protective services should work more collaboratively,
including the joint development of didactic programs designed to foster increased interaction
and to minimize conflicts or distrust.
6. Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately
trained clinical response teams to foster the appropriate evaluation, reporting, management,
and support of child abuse victims.
7. Our AMA encourages all state departments of protective services to have a medical director
or other liaison who communicates with physicians and other health care providers.
Citation: (CSAPH Rep. 2, I-09)

See also: H-515.965 Family and Intimate Partner Violence; H-515.981 Family Violence-
Adolescents as Victims and Perpetrators

Whereas, Restrictive housing, commonly practiced in the form of solitary confinement, is defined as "any type of detention that includes removal from the general inmate population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another inmate; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more;"\(^1\) and

Whereas, Based on available data, there are between 80,000 and 100,000 prisoners in restrictive housing conditions on any given day in America’s prisons and jails, including up to 25,000 in long-term isolation in supermax prisons;\(^2,3\) and

Whereas, Restrictive housing can cause significant adverse effects on an inmate’s mental health and can increase change of recidivation;\(^4,5,6\) and

Whereas, It is the position of the National Commission on Correctional Healthcare that mentally ill individuals “should be excluded from solitary confinement of any duration;”\(^7\) and

Whereas, In July 2017, a Department of Justice (DOJ) report examining the use of restrictive housing for inmates with mental illness by the Federal Bureau of Prisons (BOP) determined that current BOP policies do not adequately address the confinement of inmates with mental illness in restrictive housing units and that the BOP does not sufficiently track or monitor such inmates;\(^8\) and

\(^1\) Department of Justice Office on the Inspector General. (January, 2018), Report and Recommendations concerning the Use of Restrictive Housing, 3.


\(^6\) Craig Haney, Professor of Psychology at the University of California, Santa Cruz, before the Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, U.S. Senate, concerning “Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences” (June 19, 2012), 10-11.


Whereas, In order to mitigate the placement of inmates with mental illness in restrictive housing, the DOJ recommends that the BOP, “Assess the scalability of secure residential mental health treatment programs and develop alternatives to address their potential limitations,” and

Whereas, The BOP has formally agreed with the DOJ recommendation cited above, and

Whereas, Multiple state and local correctional departments, including but not limited to Nebraska, North Carolina, Oregon, New York City, and Middlesex County, New Jersey, are currently engaged in initiatives to significantly reduce the use of segregated housing through the advancement of safe and effective alternatives; therefore be it

RESOLVED, That our American Medical Association encourage federal, state, local, and private correctional facilities to explore, develop, and implement alternatives to restrictive housing for inmates with mental illness in order to reduce and ultimately eliminate the use of restrictive housing in this population. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY

Solitary Confinement of Juveniles in Legal Custody H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician. Citation: Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. Citation: CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

Whereas, Children are vulnerable to environmental exposures as a consequence of disproportionate food, water, and oxygen consumption relative to body size, and due to lower breathing zones, where certain air pollutants such as mercury tend to accumulate;\textsuperscript{1,2} and

Whereas, In the United States, outstanding capital investment and deferred renovations of public school buildings are estimated at over $322 billion, thereby placing students at significant risk as identified facility shortcomings are left untreated;\textsuperscript{3} and

Whereas, The Environmental Protection Agency (EPA) “does not routinely inspect and enforce...regulations in schools,” with only some specific acts mandating direct EPA intervention in school settings;\textsuperscript{4,5,6,7} and

Whereas, At least 39 states are known to have schools that supply drinking water with unsafe levels of lead, with “no scientific or practical reason” to assume that this characterization does not in fact apply to every state in America;\textsuperscript{8,9} and

Whereas, Ninety percent of the schools in America receive water from a local utility rather than private wells, thereby exempting them from EPA guidelines and regulations;\textsuperscript{10} and

Whereas, In 2006, only 51.4% of schools maintained a formal Indoor Air Quality management program, a number that has fallen in recent years;\textsuperscript{11,12} and
Whereas, In a landmark study examining Boston Public Schools, “approximately 85% of Boston
Public Schools reported leaks or water stains, 36% reported visible mold growth, 63% reported
overt pest signs, 83% reported repairs needed, and 61% reported improper chemical storage,” a
reality far from uncommon in both urban and rural settings;\(^{13}\) and

Whereas, Children in “poor health” are far more likely to receive B’s, C’s, D’s, and F’s compared
to children in “excellent/very good health;”\(^{14}\) and

Whereas, Minority students and already vulnerable populations are more likely to attend
underfunded schools with heightened risk of toxic exposures, along with heightened rates of
neighborhood violence, both which negatively impact physical and mental health;\(^{15,16,17,18}\) and

Whereas, The 2016 School Health Policies and Practices Study conducted by the CDC
highlights current shortcomings in school safety inspections, including substandard assessment
and remediation of lead, PCB, and mold exposures, indoor air quality, and chemical exposure
through the use of unsafe cleaning products;\(^{19}\) and

Whereas, As identified by the Committee to Review and Assess the Health and Productivity
Benefits of Green Schools, schools that truly prioritize overall health and performance must
establish specific criteria for dryness, indoor air quality, thermal comfort, frequent
maintenance/repair, cleanliness, and quietness;\(^{20}\) therefore be it

RESOLVED, That our American Medical Association support the development and
implementation of standardized, comprehensive guidelines for school safety and health code
compliance inspections (New HOD Policy); and be it further

RESOLVED, That our AMA support policies aiding schools in meeting said guidelines, including
support for financial and personnel-based aid for schools based in vulnerable neighborhoods
(New HOD Policy); and be it further

RESOLVED, That our AMA support creation of a streamlined reporting system for school facility
health data potentially through application of current health infrastructure. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY:
Providing Medical Services through School-Based Health Programs H-60.991; Childhood Anaphylactic Reactions D-60.976; Atrial Fibrillation and Stroke Disease H-60.951; Diagnosis and Treatment of
Attention Deficit/Hyperactivity Disorder in School-Age Children H-60.950; School-Based and School-Located Health Centers H-60.921; Quality of School Lunch Program H-150.962; Health Instruction and Physical
Education in Schools H-170.999; Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960; Improving the Health of Black and Minority Populations H-350.972; Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327; Combating Obesity and Health Disparities H-150.944; Safe Drinking Water H-135.928; Stewardship of the Environment H-135.973
Whereas, Sexual education is important in informing adolescents about biological changes during puberty, sexual health, and sexual and romantic relationships and a strong foundation in sexual education promotes healthy sexual relationships, lower rates of teenage pregnancy, and encourages safe sexual practices later in life;1,2 and

Whereas, As classified by the United States Census Bureau, if a person is a non-native speaker of the English language and has a limited ability to read, speak, write or understand English they are considered to have limited English proficiency (LEP);3 and

Whereas, The LEP population in the United States has grown 80% from 1990 to 2013 and has increased from 6% of the total United States population in 1990 to 8.5% in 2013;3 and

Whereas, The estimated percentage of students with LEP in United States public schools is 9.3%, of which 76.5% speak Spanish/Castilian;4 and

Whereas, The highest rates of teenage pregnancy in the United States are in the Latino community;5 and

Whereas, The STI rates for Latina adolescents is approximately two times higher than non-Latina White adolescents (8.93 and 4.3 per 1000, respectively), and 24% of newly diagnosed cases of HIV in persons aged 20 to 24 were Latino while 16% were caucasian;6,7,8 and

---

Whereas, Understanding aspects of Latino culture, such as social class, education, socioeconomic status, country of origin, religiosity, the changing role of women, the impact of the media, and view of family planning programs, are crucial for effective sex education efforts in the Latino community;⁹ and

Whereas, There is evidence that language concordant and culturally competent sexual education taught both in English and Spanish results in reduced contraction of HIV in Latino populations, increased days of protected sex, and more frequent condom use;¹⁰,¹¹ and

Whereas, AMA Policy H-170.968 currently supports comprehensive sex education, but it does not encourage schools to use language concordant materials for LEP pupils; therefore be it

RESOLVED, That our American Medical Association amend policy H-170.968 by addition to read as follows:

SEXUALLY EDUCATION, SEXUAL VIOLENCE PREVENTION, ABSTINENCE, AND DISTRIBUTION OF CONDOMS IN SCHOOLS H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; and (h) include culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and (10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Received: 04/26/18

RELEVANTAMA POLICY

An Updated Review of Sex Education Programs in the United States H-170.962
Our AMA: (1) recognizes that increasing sexually transmitted disease (STD) and human immunodeficiency virus (HIV) transmission rates among youth, as well as a recent increase in the national teen pregnancy rate, indicate a gap in public health education and should be addressed; and that comprehensive-based sex education is currently the most effective strategy to address these public health problems; and (2) supports the redirection of federal resources toward the development and dissemination of more comprehensive health and sex education programs that are shown to be efficacious by rigorous scientific methodology. This includes programs that include scientifically accurate education on abstinence in addition to contraception, condom use, and transmission of STDs and HIV, and teen pregnancy.
Citation: (CSAPH Rep. 7, A-09)

Human Sexuality Education H-170.966
Our AMA encourages physicians to assist parents in providing human sexuality education to children and adolescents.
Citation: (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

See also: Addressing Immigrant Health Disparities H-350.957; Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; Comprehensive Health Education H-170.977; Education on Condom Use H-170.965
Whereas, Our AMA has formally recognized gun violence as a public health issue; and

Whereas, Public health research has led to interventions which save countless lives such as research on smoking and motor vehicle deaths; and

Whereas, US homicide rates were seven times higher than in other high-income countries, driven by a gun homicide rate that was 25.2 times higher. For 15- to 24-year-olds, the gun homicide rate in the United States was 49 times higher. Unintentional firearm deaths were 6.2 times higher in the United States. The overall firearm death rate in the United States from all causes was ten times higher. Ninety % of women, 91% of children aged <14 years, 92% of youth aged 15 to 24 years, and 82% of all people killed by firearms were from the United States; and

Whereas, The Rand Corporation has recently produced a review of current literature regarding effectiveness of current state level gun laws; and

Whereas, The Rand report identifies specific statutory interventions likely to reduce gun violence, gun related suicides and accidental shootings; and

Whereas, Policy dealing with public health issues should be based on evidence; and

Whereas, The Rand report cites the lack of funded research on the causes and potential remedies for gun violence as a barrier to addressing the problem; and

Whereas, Our AMA policy calls for the AMA to “actively lobby Congress to lift the gun violence research ban”; therefore be it


be it further

RESOLVED, That our AMA work with other physician organizations to actively lobby for restoration of funding for gun violence research at the Centers for Disease Control and Prevention and elsewhere (Directive to Take Action); and be it further

1 Am J Med. 2016 Mar;129(3):266-73
2 https://www.rand.org/pubs/research_reports/RR2088.html
RESOLVED, That our AMA review the Rand report on gun violence and other credible sources of research on causes and effective policy to reduce gun violence and report back at the 2018 Interim Meeting with findings and recommendations for further advocacy to reduce gun violence in the US. (Directive to Take Action)

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

Received: 05/01/18

RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.
Citation: Res. 1011, A-16;

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
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.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)
Whereas, The AMA recognizes that the growing crisis of poverty, homelessness, and decreased number of mental health facilities has led to increasingly more Medicaid patients visiting the Emergency Department for preventable and predictable conditions (AMA Policy H-160.903); and

Whereas, Current healthcare delivery to homeless patients contributes to poor health outcomes, increased healthcare spending, and increased medical provider frustration;¹⁻³,⁴ and

Whereas, Without a formalized post-hospitalization arrangement for homeless patients, a de facto process of care has emerged that leads to suboptimal discharge arrangements, provider burnout, poor patient outcomes, and an overall increase in cost of patient care;¹⁻⁵,⁶ and

Whereas, Medical Respite Care (MRC) is acute and post-acute medical care for homeless patients who are too sick to recover on the streets but not sick enough to be kept inpatient;⁷ and

Whereas, MRC centers are third-party organizations that provide homeless patients MRC, including access to nursing care, behavioral health services, substance abuse services, case managers, and primary care providers;⁷⁻⁹,¹⁰ and

Whereas, MRC is associated with fewer hospital readmissions, and a reduction in the total amount of time patients spend in the hospital across multiple parameters as compared to patients who were unable to access MRC care;⁷,⁸ and

⁷ Doran, KM, Ragins KT, Gross CP, et. al. Medical respite programs for homeless patients: A systematic review. J Health Care Poor Underserved. 2013, 24, 499–524
Whereas, MRC report overall cost-savings, particularly when compared with the cost of
hospitalization, with demonstrated cost avoidance for hospitals ranging from $3.5 to $5.5 million
annually;8,11 and

Whereas, As stated in the Standards for Medical Respite Care, MRC quality standards only
require self-audits and do not promote standardization across facilities;12 and

Whereas, Because the vast majority of MRC centers do not receive funding from Medicaid,
MRC programs utilize an unreliable patchwork of funding mechanisms across the public and
private sector, leading to challenges of incorporating and streamlining MRC;11,13 therefore be it

RESOLVED, That our American Medical Association study funding, implementation, and
standardized evaluation of Medical Respite Care for homeless persons. (Directive to Take
Action)

Fiscal Note: not yet determined

Received: 04/26/18

RELEVANT AMA POLICY

Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the
health care costs of treating the chronically homeless through clinically proven, high quality, and cost
effective approaches which recognize the positive impact of stable and affordable housing coupled with
social services; and (2) supports the appropriate organizations in developing an effective national plan to
eradicate homelessness.
Citation: (Res. 401, A-15)

The Mentally Ill Homeless H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless
mentally ill population, should include the following components: (a) access to care (e.g., integrated,
comprehensive services that permit flexible, individualized treatment; more humane commitment laws
that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for
homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address
common health problems of the homeless population and promoting care that is sensitive to the
overriding needs of this population for food, clothing, and residential facilities); (c) program development
(e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential
placements; developing specific programs for multiproblem patients, women, children, and adolescents;
supporting the development of a clearinghouse; and promoting coalition development); (d) educational
needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and
residency training programs to develop model curricula and to incorporate in teaching programs content
on health problems of the homeless population, including experiential community-based learning
experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical
education training programs that include the special treatment needs of the homeless population.
Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06;
Reaffirmed: CMS Rep. 01, A-16;

See also: Transforming Medicaid and Long-Term Care and Improving Access to Care for
the Uninsured H-290.982

11 National Health Center for the Homeless Council, Inc. “Medical Respite Care: Reducing Costs and Improving Care” (2011)
12 National Health Care for the Homeless Council, Inc. “Standards for Medical Respite Programs” (2016).
13 Dobbins, Julia. Financing Medical Respite Care: A Practical Discussion to Ensure Sustainability. National Healthcare for the
WHEREAS, Thirty-eight percent (approximately 61 million) of women residing in the U.S. are members of a racial or ethnic minority populations and face disparities in obstetric outcomes; and

WHEREAS, Studies have shown poor obstetric outcomes (e.g., preterm birth), maternal morbidity, and inadequate prenatal care is higher among racial/ethnic minority women in the U.S.; and

WHEREAS, Poor obstetric outcomes that disproportionately affect racial/ethnic minorities include the higher incidences of congenital abnormalities (e.g., spina bifida and anencephaly); fetal demise (11.3 per 1,000 for Blacks compared to 5.0 per 1,000 for Non-Hispanic Whites); preterm birth (16.3% Blacks compared to 10.2% non-Hispanic Whites); and fetal growth restriction (15.9 per 1,000 for Blacks compared to 8.3 per 1,000 for non-Hispanic Whites); and

WHEREAS, The birth prevalence of spina bifida is 4.18 per 10,000 births among Hispanic women, versus 3.37 per 10,000 for non-Hispanic white women; and

WHEREAS, Among Asian women, Indian and Pakistani women have the highest risk of low birthweight newborns at term; and

WHEREAS, Disparities in preterm births account for 80% of the Black-White disparity in infant mortality (in the U.S. in 2006, Blacks had an overall preterm birth rate of 18.4% compared to the general population's rate of 12.8%); and

WHEREAS, Polymorphisms in maternal and fetal genes for IL-1, IL-6 and other inflammatory factors may be associated with an increased risk of spontaneous preterm birth among Black women over other populations; and

WHEREAS, These polymorphisms could also modify the risk of preterm birth associated with genital infections among certain female minority populations; and

WHEREAS, In 2009, the prevalence of severe maternal morbidity in the U.S. was 129 per 10,000, representing a 75% increase since 1999; and

WHEREAS, Non-Hispanic Black women are twice as likely to experience severe maternal morbidity than Caucasians; and
Whereas, Among all women, pregnancy-related hypertension rates are the highest in Non-Hispanic Black women. Among Asian women, Filipina and Samoan women have higher risk than women from other subgroups; and

Whereas, A report by the Centers for Disease Control and Prevention on Gestational Diabetes, found that Hispanic and Asian/Pacific Islander women at a greater risk for development of gestational diabetes (16.3% and 12.1% respectively) compared to Caucasian women (6.8%)\[16]; and

Whereas, A report by the American Diabetes Association found that racial and ethnic minorities [Black (1.69), Hispanic (1.42), and Asian/Pacific Islander (1.25)] had higher rates of pregnant women with pre-existing diabetes compared to pregnant Caucasian women even after adjusting for maternal age\[17]; and

Whereas, Studies have shown that Asian women are at an increased risk for gestational diabetes, prolonged second stage of labor, and perineal lacerations compared to Caucasian women\[7,18-20]; and

Whereas, Research on Asian subgroups have shown that Filipina women had the highest risk of gestational hypertension/preeclampsia; Pacific Islander women had the highest risk of macrosomia; and Indian/Pakistani women had the highest risk of preterm delivery, gestational diabetes, and diabetes mellitus\[7,18-22]; and

Whereas, The complex etiologies of these disparities include social constructs and variations in access to health care\[23]; and

Whereas, Despite the 1998 FDA mandate to fortify cereal grains in the U.S., adequate intake of folic acid remains low in Hispanic groups\[24,25]; and

Whereas, Black women are also more likely to experience higher rates of maternal morbidity (e.g., hypertensive disorders of pregnancy), some of which may be attributable to genetic factors as well\[23]; and

Whereas, Studies have shown that maternal stress plays a role in preterm birth risk, in particular Black and Native Indian/Alaska Natives report undergoing chronic stressors during pregnancy\[26-28]; and

Whereas, Racial and ethnic minorities have a higher incidence of being overweight and/or obese pre-pregnancy, which have been shown to contribute to pregnancy complications such as preterm birth, fetal death, macrosomia, gestational diabetes and cesarean delivery\[29-31]; therefore be it

RESOLVED, That our American Medical Association work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices in ethnic minorities to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/01/18
References:


RELEVANT AMA POLICY
H-350.974 Racial and Ethnic Disparities in Health Care
D-420.993 Disparities in Maternal Mortality
H-420.995 Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns
Whereas, The AMA-SPS mission is to engage physicians age 65 and above, both active and
 retired, to promote policies, products and services relevant to senior physicians; and

Whereas, The number of seniors in the United States is growing exponentially, with currently 46
 million people age 65 or older with the number expected to grow to 73 million in the next 15
 years1; and

Whereas, The “Baby Boomer” generation (generally accepted as birth dates between 1946 to
 1964) is 74.9 million2; and

Whereas, Large numbers of these groups live independently in retirement communities not
 subject to any state or federal regulations as are required for assisted living, extended care and
 nursing homes; and

Whereas, The AARP has published its second edition of “Where We Live: Communities for All
 Ages” with a focus on communities in the forefront in addressing the needs of an aging
 population3; and

Whereas, Many senior physicians live in such communities and could be a resource for their
 communities in matters of health and wellness, enhancing the health of the community’s
 residents, were there a template of suggestions to guide their efforts; and

Whereas, Although there are guidelines for immunizations from the CDC and publications
 touting the validity of exercise programs for the elderly, they are not cohesive and in “one
 place”; and

Whereas, There are no guidelines for independent living communities (on activities) that could
 prevent communicable diseases or even save lives (e.g. alcohol/soap hand dispensers in
 communal areas, maintenance suggestions for decorative fountains and cooling towers,
 placement of AEDs [AEDs — automated external defibrillators — can be found in almost every
 school building and airport but how many are in senior living facilities?]); and

Whereas, Senior citizens have special needs that may include safety features (e.g. wider
 doorways, absence of area rugs, leveling of doorsills), accommodations for disabilities,
 improved bathroom accessibility and enhanced lighting; and
Whereas, Norman Cohen, MD, a respected orthopedic surgeon at Highland Park Hospital in Illinois for 30 years, who, upon retirement, then practiced orthopedics at the Navajo Indian Reservation in Arizona and New Mexico over a five-year period, who lived in a senior retirement community and, as a member of the AMA Senior Physicians Section, wished to continue helping his fellow residents by submitting this resolution before he passed away in February 2018; therefore be it

RESOLVED, That our American Medical Association, in cooperation with other interested parties such as the public health community, geriatric specialties, and AARP, study the development of a document that could guide best health practices for the senior independent living community. (Directive to Take Action)

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

Received: 05/01/18

References:
WHEREAS, Gun violence is a public health and medical issue of immediate importance and our
responsibility as a medical community is to contribute to the solution of prevention; and

WHEREAS, In 2013 our AMA joined 51 other specialty societies in letters to our President and
congress to highlight mental health issues involved in violence prevention, and in 2017 our AMA
came together with the American Bar Association to discuss the crisis of gun violence in
Chicago, we prioritized lifting the ban and restoring funding to the CDC and federal agencies to
study gun violence and in the interim our statistics come from other sources; and

WHEREAS, Currently an average of 7 children and teens under 20 are killed by guns every day
and more than 1 in 5 US teenagers (14-17 years old) report having witnessed a shooting, and
an average of 34 Americans are murdered with guns every day and 151 are treated for gun
assaults every day in an emergency room;¹ and

WHEREAS, 60% of gun sales occur with a background check, yet those states with weaker gun
laws on average lead to more gun deaths;¹ and

WHEREAS, America is an outlier on gun violence because it has many more guns than other
developed nations with 4.4% of the world’s population but almost half of the civilian owned guns
around the world;² and

WHEREAS, Change is imperative with rampant gun violence in both urban communities and mass
shootings; with 1,600 mass shootings since Sandy Hook elementary school in 2012 with a total
of 1,800 killed and 6,400 wounded; therefore be it

RESOLVED, That our American Medical Association advocate that a valid permit be required
before the sale of all rapidly-firing semi-automatic firearms (New HOD Policy); and be it further

RESOLVED, That our AMA study options for removing access to firearms for those who may be
a threat to themselves or others (Directive to Take Action); and be it further

RESOLVED, That our AMA study options for improving the mental health reporting systems and
patient privacy laws at both the state and federal levels and how those can be modified to allow
greater information sharing between state and federal government, law enforcement, schools
and mental health professionals to identify, track and share information about mentally ill
persons with high risk of violence and either report to law enforcement and/or the National
Instant Criminal Background Check System, with appropriate protections. (Directive to Take
Action)
REFERENCES
2. Harvard School of Public Health Injury Control Research Center, https://www.hsph.harvard.edu/hicrc/firearm-researcher-surveys/
3. http://www.gunviolencearchive.org/Gun Violence Archive compiled database since 2013 tracing reported shooting events (esp. Since CDC recent data is behind)

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

Received: 05/02/18

RELEVANT AMA POLICY

Firearm Availability H-145.996
Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers; (2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPHR. 1, A-15; Modified: BOT Rep. 12, A-16;

Increasing Toy Gun Safety H-145.974
Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.
Citation: (Res. 406, A-15)

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.
Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

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

Gun Safety H-145.978
Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.
Citation: (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPHR. 1, A-10; Reaffirmation A-13)

See also:
Introduced by: Illinois

Subject: Mandatory Influenza Vaccination Policies for Healthcare Workers

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Policies requiring health care workers (HCW) to obtain influenza vaccinations as a condition of employment are gaining popularity; and

Whereas, Recent studies, such as the Cochrane review, have shown that policies requiring HCW influenza vaccinations do not reduce patient risk; and

Whereas, There has never been a study to investigate the cumulative toxicity of annual influenza vaccination administration; and

Whereas, The principle of herd immunity does not apply when ascribed to an occupational population or when the vaccine efficacy rate is low or unknown; and

Whereas, A recent CDC sponsored study concluded that spontaneous abortion “was associated with influenza vaccination in the previous 28 days” (adjusted odds ratio of 2:0); and

Whereas, Medical center vaccination consent forms for influenza vaccinations may contain the phrase (or something similar) that the employee will defend, indemnify, and hold harmless the medical center’s directors, officers, medical staff, employees, and agents from all claims, demands, and causes of action including court costs and attorney fees directly or indirectly arising from any action or proceedings arising from any adverse side effect; therefore be it

RESOLVED, That our American Medical Association enact as policy that no health care worker should be terminated from employment due solely to their refusal to be vaccinated for influenza.

(Directive to Take Action)

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

Received: 05/02/18
Whereas, American consumers currently must contend with as many as a dozen different expiration date label designations on foods, medications and other perishable products, resulting in confusion and waste; and

Whereas, Consumers generally interpret date labels as an indication that food is no longer safe to eat, though the label may actually only represent the manufacturer’s guess at its peak quality; and

Whereas, The largest grocery industry trade associations have introduced guidelines urging manufacturers to use only the standardized safety designation “use by” and the quality descriptor “best if used by” for product date labels; and

Whereas, Voluntary guidelines will not resolve the associated consumer confusion (whether accidental or intentional) and any qualitative date label will continue to promote the waste of safe food and products; therefore be it

RESOLVED, That our American Medical Association endorse federal standardization of date labels on foods and other products to ensure that they address safety concerns. (Directive to Take Action)

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

Received: 05/02/18
Whereas, Evidence-based research indicates that even a small amount of lead in a child’s body can cause serious health problems; and

Whereas, Other studies have demonstrated lead’s compromising effects on child health, the immune system, and association with impairments in neurobehavioral factors such as a child’s learning skills, hearing, and self-regulatory ability resulting in delinquent behavior; and

Whereas, Children may be more susceptible to the adverse health effects of chemical, physical, and biological hazards than adults, while having reduced immunity, immaturity of organs and functions than adults; and

Whereas, Rapid growth and development can make children more vulnerable to the toxic effects of environmental hazards than adults; and

Whereas, During critical developmental stages, children spend much of their day within school environments; and

Whereas, The current action limit for lead in drinking water of 15 ppb is a regulatory measure, not a public health measure; and

Whereas, Research shows that there is no 100 percent "safe" level of lead in drinking water for school children; and

Whereas, It is imperative that standardized, sustainable protocols be developed to ensure school water safety; and

Whereas, Such protocol should include detailed water monitoring and maintenance standards and schedules, guidance on flushing of pipes and filter replacement/maintenance as deemed necessary given the condition of the water system, technical assistance, and both regulatory and independent oversight to ensure such protocols are sustained by state, local, and school system entities; and

Whereas, There are currently no national regulations requiring the testing of school water for lead, copper, and other metals as well as biological contaminants; and

Whereas, All children, regardless of the state or community in which they reside, require protection against metal, chemical and biological contamination in the water made available to them in schools; therefore be it
RESOLVED, That our American Medical Association amend policy H-60.918 by addition to read as follows:

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918
1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water.
5. Our AMA supports the creation and implementation of standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA actively pursue changes to the federal lead and copper rules consistent with AMA policy H-135.928. (Directive to Take Action)

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

Received: 05/02/18

RELEVANT AMA POLICY

Safe Drinking Water H-135.928
Our AMA supports updates to the U.S. Environmental Protection Agency’s Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:
(1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water; (2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations; (3) Informing consumers about the health-risks of partial lead service line replacement; (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
(5) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health; (6) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations; (7) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead; and
8) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act. Citation: Res. 409, A-16;

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918
1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water. Citation: Res. 428, A-16;
Whereas, The dangers of wire-bristle grill brushes have been documented; and

Whereas, The study, "Epidemiology of Wire-Bristle Grill Brush Injury in the United States, 2002-2014" published in the SAGE Journals American Academy of Otolaryngology-Head and Neck Surgery on March 1, 2016, estimated that between 2002-2014, more than 1,600 emergency department visits occurred as a result of wire-bristle brush injuries; and

Whereas, Most people using wire-bristle grill brushes are likely not aware of the potential risk from bristles that break off and adhere to the grill; and

Whereas, These bristles can stick to the food being cooked and then accidentally ingested; and

Whereas, "Depending on the site of injury, multiple specialties—including emergency medicine, radiologists, otorhinolaryngology-head and neck surgery, and general surgery—may be involved in the care of these patients"; and

Whereas, A lack of awareness can result in a delay in diagnosis and medical complications; and

Whereas, Ingested wire-bristles can become a surgical emergency; therefore be it

RESOLVED, That our American Medical Association request that the appropriate federal agency require the placement of a warning label on all wire-bristle grill brushes informing consumers about the possibility of wire bristles breaking off and being accidentally ingested.

(Directive to Take Action)

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

Received: 05/02/18

Sources:
Whereas, As physicians, parents, and grandparents we are concerned about the ongoing issues of rapes, sexual abuse, and physical abuse on college campuses; and

Whereas, The sequelae of rape, sexual abuse, and/or physical abuse can include physical and psychological problems; and

Whereas, Rape, sexual abuse, and/or physical abuse may be associated with the inappropriate use of alcoholic beverages; therefore be it

RESOLVED, That our American Medical Association evaluate the issues of rape, sexual abuse, and physical abuse on college campuses and the role state medical societies and our AMA can play in helping to address and resolve these issues (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses. (Directive to Take Action)

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

Received: 05/02/18

RELEVANT AMA POLICY

Addressing Sexual Assault on College Campuses H-515.956
Our AMA supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting.
Citation: Res. 402, A-16;

Sexual Assault Survivor Services H-80.998
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
Citation: Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17;

Sexual Assault Survivors H-80.999
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (A) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (B) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (C) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (D) be informed of these rights and the policies governing the sexual assault evidence kit; and (E) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.


E-8.10 Preventing, Identifying and Treating Violence and Abuse

All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.

To protect patients well-being, physicians individually should:

(a) Become familiar with:
   (i) how to detect violence or abuse, including cultural variations in response to abuse;
   (ii) community and health resources available to abused or vulnerable persons;
   (iii) public health measures that are effective in preventing violence and abuse;
   (iv) legal requirements for reporting violence or abuse.

(b) Consider abuse as a possible factor in the presentation of medical complaints.

(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.

(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in normal families, is a private matter best resolved without outside interference, or is caused by victims own actions.

(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.

(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.

(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
   (i) inform patients about requirements to report;
   (ii) obtain the patients informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patients refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.

(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.

Collectively, physicians should:

(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.

(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.

(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.

(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.

(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

AMA Principles of Medical Ethics: I,III

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016
Whereas, The U.S. Food and Drug Administration’s (FDA’s) new regulations require calorie information on restaurant menus for chains with 20 or more locations by May 7, 2018; and

Whereas, Restaurants are required to provide written nutrition information on their menu items (e.g. total fat, calories from fat, saturated fat, trans fat, cholesterol, sodium, total carbohydrates, dietary fiber, sugars and protein), but can have this information on posters, tray liners, signs, counter cards, handouts, booklets, computers, or kiosks; and

Whereas, Food in hospital cafeterias and inpatient meals will not have to list calorie or nutrition information; and

Whereas, Obesity is a serious concern in adults and children and is associated with poorer mental health outcomes, reduced quality of life and can lead to death or chronic illnesses such as diabetes, heart disease, stroke and some forms of cancer; and

Whereas, Our AMA has longstanding policy supporting providing consumers with nutrition information (AMA Policy H-150.945); therefore be it

RESOLVED, That our AMA modify Policy H-150.949 by addition to read as follows:

Healthy Food Options in Hospitals H-150.949
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises.
2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthful food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthful beverages.
3. Our AMA hereby calls for hospital cafeterias and inpatient meal menus to publish nutrition information similar to what is being required for chain restaurants. (Modify Current HOD Policy)

REFERENCES
Food Facts from FDA https://www.fda.gov/Food/LabelingNutrition/ucm436722.htm

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

Received: 05/02/18
RELEVANT AMA POLICY

Healthy Food Options in Hospitals H-150.949
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises.
2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthful food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthful beverages.

Citation: Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17
Reference Committee E

BOT Report(s)

10  Over-the-Counter Contraceptive Drug Access
22  In-Flight Emergencies
29  Support for Service Animals, Emotional Support Animals, Animals in Healthcare and Medical Benefits of Pet Ownership
30  In-Flight Emergencies
38  Timely Referral to Pain Management Specialist

CSAPH Report(s)

02  Drug Shortages: Update
03  Prescription Drug Donation

Resolution(s)

501  Synthetic Cannabinoids
502  Expedited Prescription CBD Drug Rescheduling
503  Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians
504  Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex)
505  Researching Drug Facilitated Sexual Assault Testing
506  Non-Therapeutic Gene Therapies
507  Opioid Treatment Programs Reporting to Prescription Monitoring Programs
508  Reintroduction of Mitochondrial Donation in the United States
509  Opposing the Classification of Cannabidiol as a Schedule 1 Drug
510  Alcohol Use and Cancer
511  Education for Recovering Patients on Opiate Use After Sobriety
512  Physician and Patient Education About the Risk of Synthetic Cannabinoid Use
513  Hand Sanitizer Effectiveness
514  Effects of Virtual Reality on Human Health
515  Information Regarding Animal-Derived Medications
516  Waste Incinerator Ban
517  Impact of Natural Disasters on Pharmaceutical Supply and Public Health
REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-18

Subject: Over-the-Counter Contraceptive Drug Access (Resolution 110-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee E
(Douglas Martin, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting, Resolution 110-A-17, “Over-the-Counter Contraceptive Drug Access,” introduced by the Illinois Delegation and referred by the House of Delegates (HOD), asked:

That our American Medical Association (AMA) condemn age-based, cost-based, and other non-medical barriers to contraceptive drug access;

That our AMA adopt policy supporting equitable access to over-the-counter (OTC) contraception, including those forms of contraception recommended for OTC sale, patient risk assessment screening tools, and prescribing by non-physicians;

That our AMA support policy solutions that prohibit cost-sharing obstacles to OTC contraceptive drug access, and full coverage of all contraception without regard to prescription or OTC utilization, since all contraception is essential preventive health care; and

That our AMA advocate for the legislative and/or regulatory mechanisms needed to achieve improvements for OTC contraceptive drug access and quality.

This report outlines the issues associated with OTC contraceptive drug access and provides a recommendation based on current evidence. Access to emergency contraception is not a focus of this report.

BACKGROUND

Unintended pregnancy is a major public health issue in the United States accounting for approximately 45% of all pregnancies and is associated with increased risks for negative outcomes for mothers and infants and increased health care costs. Currently, OTC oral contraception is available in more than 100 countries. Although no OTC oral contraceptives are available in the United States, interest in their availability is high, with surveys finding that 62% of U.S. women support such access. Oral contraceptive pills consist of the hormones estrogen and/or progestin and are taken orally once per day. Three types are available in the United States: the combination pill with estrogen and progestin, the progestin-only pill, and the continuous use pill. The three types of oral contraceptives vary in their hormonal composition and the regimen for their use. Emergency contraceptive pills,
which consist of the progestin levonorgestrel, are also considered a type of oral contraceptive not
intended for daily use, but that can be used to prevent pregnancy after unprotected sex. Oral
contraceptives are primarily used for pregnancy prevention, but they are also used to treat other
health conditions such as menstrual pain, irregular menstruation, fibroids, endometriosis-related
pain, menstrual-related migraines, and acne.

Policy statements from the American Academy of Family Physicians (AAFP), the American
College of Obstetricians and Gynecologists (ACOG), and American Public Health Association
(APHA) support OTC oral contraceptive access. An Oral Contraceptives Over-the-Counter
Working Group was formed in 2004 with the aims “to improve access to contraception and reduce
disparities in reproductive health outcomes by making a low-cost oral contraceptive product
available OTC in the United States.” Over 80 organizations have signed onto the Working Group’s
statement of purpose, including the American Academy of Pediatrics and ACOG.

A variety of concerns have been raised in discussions of OTC oral contraceptives, including
barriers to access, cost of a potential OTC oral contraceptive, and safety, which are briefly
discussed below.

BARRIERS TO CONTRACEPTIVE USE

One third of women at risk for unintended pregnancy who attempted to obtain a prescription for
contraception reported having trouble doing so. Access and cost issues are the most commonly
cited reasons why women do not use oral contraceptives, use them inconsistently, or discontinue
use early. Women may experience difficulty obtaining oral contraceptives for a variety of reasons
including the prescription requirement, lack of insurance, and inaccessibility when travelling.
Research suggests that OTC access would increase the use of contraception and facilitate
continuity of use. Additional time and cost benefits include less travel, fewer physician office
visits, and less time off work.

INSURANCE COVERAGE AND ACCESS

Under the Patient Protection and Affordable Care Act (ACA), most private health insurance plans
are required to provide coverage for at least one product in each of the 18 contraceptive methods
approved by the U.S. Food and Drug Administration (FDA) for women with no cost-sharing. This
coverage also applies to OTC contraceptives used by women, such as emergency
contraception, barrier methods, and spermicide, but a prescription is required. Plans are not
required to cover male contraception methods such as vasectomy and male condoms. Federal law
requires Medicaid programs to cover family planning services and supplies without cost-sharing.
States that expanded Medicaid under the ACA must follow the ACA requirements for oral
contraceptives. Coverage for oral contraceptives is required in the Indian Health Service and in the
TRICARE program, but is not a requirement for Medicare. Regulations exist to exclude some or all
contraceptive methods and services from health plans provided by employers who morally object
to oral contraceptive use or have religious exemptions. However, enforcement of these regulations
has been blocked by the courts.

Cost is an important consideration. A survey of U.S. women indicated that the maximum they are
willing to pay for an OTC oral contraceptive is $20. A cost modeling analysis determined that full
insurance coverage of an OTC oral contraceptive without any out-of-pocket expenses would result
in the largest reduction of unintended pregnancies. The analysis also found that use would be
highest, and the estimated reduction in unintended pregnancy greatest, among low-income women,
if an OTC oral contraceptive was fully covered by insurance with no cost-sharing. Full coverage
would also be cost effective for insurers because of the savings associated with averting unintended pregnancies.\textsuperscript{12} AAFP, ACOG, and APHA policy statements include support for insurance coverage of OTC contraceptive products without the need for a prescription. Federal or state legislative or administrative changes to ACA policy would be needed to include non-prescribed contraceptives in coverage and pharmacies would need billing mechanisms for processing claims without a prescription. Billing mechanisms that do not rely on a prescription are used by Medicaid programs in several states to cover OTC emergency contraception. These billing mechanisms have been incorporated into existing software, and it may be feasible for additional insurers to incorporate the ability to process claims without a prescription. Computerized kiosks providing a prescription for contraception after the completion of a self-screening tool are currently being piloted, and the potential exists for women to be able to generate a prescription in a pharmacy or at home using web-based tools from insurers.\textsuperscript{13} Congress has introduced legislation addressing this issue, and a few states have passed laws requiring insurers to cover OTC contraceptives without a prescription.\textsuperscript{3}

Concerns have been raised that overall access to oral contraceptives may be hindered if an OTC product becomes available and the switch negatively affects insurance coverage for other prescription oral contraceptives or creates new barriers to obtaining these products.\textsuperscript{13} Insurers may employ formulary management strategies such as preferred drug lists, prior authorization, and step-therapy programs.\textsuperscript{13}

Some states allow pharmacists to provide oral contraceptives without physician oversight. Policies in such states vary including age requirements, type of contraceptive allowed, and length of supply. Some discussion has centered around the issue of increasing the dispensing period of oral contraceptives to a 12-month supply to facilitate access. Dispensing requirements vary by insurer and laws requiring coverage for a 12-month supply have been passed in several states.\textsuperscript{3} Additionally, online services and smartphone applications have emerged for women to speak with providers via video, obtain prescriptions, and order oral contraceptives from mail delivery services. Requirements and cost vary based on the application.\textsuperscript{3}

**SELF-SCREENING**

In 2016, the U.S. Centers for Disease Control and Prevention (CDC) published an updated Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), an evidence-based list of conditions and medications considered contraindications to contraceptive methods. The U.S. MEC states that all contraindications for combined oral contraceptives, other than hypertension, can be identified by reviewing a woman’s medical history; progestin-only oral contraceptives have a shorter list of contraindications that does not include hypertension.\textsuperscript{1,14}

Concern has been raised from physicians that women might not be able to self-diagnose contraindications associated with oral contraceptives or may ignore label warnings. Studies have shown that women can accurately use checklists to determine if they have contraindications to hormonal contraception; in one study, 96% of cases evaluated demonstrated agreement between a women’s assessment of her contraindications using a checklist and a clinician’s independent evaluation, and women often take a more conservative approach compared with clinicians.\textsuperscript{15,16}

Another concern that has been voiced about OTC oral contraceptives is that women would not obtain recommended preventive screenings for cervical and breast cancer and for sexually transmitted infections that often accompany physician visits for contraceptives. The World Health Organization, FDA, and ACOG state that oral contraceptives can be safely and effectively prescribed without a pelvic examination. Although experts have stated that that preventive screening is not medically necessary or required for the provision of hormonal contraception,\textsuperscript{17}
many clinicians continue to link the services. A recent study found that a high proportion of
women in Texas who acquired oral contraceptives from Mexico without a prescription obtained
screening tests at a rate higher than the U.S. national average.

AGE RESTRICTIONS

Adolescents face age-related barriers to contraception access, which could be reduced with OTC
access, including concerns about disclosing their confidential information and their ability to access
services without the consent of a parent or guardian. An age restriction for an OTC product is
uncommon, but is a relevant topic related to OTC oral contraceptives. Some states that allow
pharmacists to provide oral contraceptives include age restrictions in their policy. When
levonorgestrel emergency contraception became available OTC, there was an age restriction that
was later removed. The consensus is that oral contraceptives are safe and the prevalence of
contraindications is greater in women 35 years and older compared to younger users and is low
among women of all ages for a progestin-only product.

A 2011 survey revealed that most women do not support an age restriction for oral contraceptives
and a survey of teenagers found that approximately three-quarters supported oral contraceptive
OTC access. Additionally, studies showed that sexual risk-taking behaviors did not increase in
teenagers when their access to emergency contraception increased, and the increased access may
aid in improving their use of more effective contraception methods.

FDA APPROVAL PATHWAY

The FDA has pathways in place for the development and regulation of OTC products, the
monograph process or the New Drug Application (NDA) process. Products for which an OTC
monograph does not exist or that do not conform to an existing final monograph, as is the case for
oral contraceptives, primarily use the NDA process. A sponsor seeking to market a product OTC,
either as a new NDA or a switch from a prescription product, applies to the Division of
Nonprescription Drug Products in the Office of Drug Evaluation IV.

Once a sponsor submits an NDA to change one oral contraceptive product that is already registered
as a prescription product to an OTC product, there are consumer studies, safety data evaluations,
and regulatory reviews required by the FDA. The required information includes the following:

- Post-market safety data review: Toxicity data, addictive properties, and interactions with
  other drugs are evaluated to establish the safety of the medication as a prescription product.
- Label comprehension study: Ability of potential users to understand OTC labeling of
  medication and take the medication as indicated without a physician’s explanation are
  evaluated.
- Self-selection study: Ability of potential users to determine whether the product is
  appropriate for them is evaluated.
- Actual use study: Correct use of the product by potential users in a simulated OTC
  environment is evaluated.
- Human factors study: Interacting with the product by potential users is evaluated.

Following collection and submission of data, FDA staff reviews and evaluates the findings in
consultation with an advisory committee. Many of the required studies can occur simultaneously;
however, this process can take three to four years from NDA initiation until an application is
approved. Evidence published in peer-reviewed literatures suggests that oral contraceptives
generally meet FDA requirements for an OTC switch.
Over fifty formulations, accounting for hundreds of different branded products of oral contraceptives, exist as prescription medications. Only the specific product for which an NDA was submitted will be evaluated for OTC sale. All others would remain as prescription medications unless an NDA or Abbreviated New Drug Application (ANDA), in the case of a generic with the same drug formulation, is submitted and required studies are individually performed for each one.

Progestin-only oral contraceptives have fewer and more rare contraindications than combined oral contraceptives, which may make them a better candidate for FDA approval for OTC sale. A progestin-only product has been put forward as a potential first candidate for an OTC oral contraceptive. In December 2016, Ibis Reproductive Health announced a partnership with HRA Pharma to conduct the research needed and submit an application to the FDA to bring a progestin-only oral contraceptive pill to the United States OTC market. The 2006 FDA approval of OTC sale for progestin-only levonorgestrel emergency contraception, which contains a higher dose of progestin than is found in oral contraceptives, may make it easier to obtain approval for an OTC progestin-only product than for a combined oral contraceptive product.

CURRENT AMA POLICY

Several current AMA policies address contraceptives. Policy D-75.995, “Over-the-Counter Access to Oral Contraceptives,” directs our AMA to recommend to the FDA that manufacturers of oral contraceptives be encouraged to submit the required application and supporting evidence for the Agency to consider approving a switch in status from prescription to OTC for such products and encourages the continued study of issues relevant to over-the-counter access for oral contraceptives. Policy H-75.990, “Development and Approval of New Contraceptives,” encourages manufacturers to conduct post-marketing surveillance studies of contraceptive products. Policy H-75.998, “Opposition to HHS Regulations on Contraceptive Services for Minors,” opposes regulations that require parental notification when prescription contraceptives are provided to minors through federally funded programs, since they create a breach of confidentiality in the physician-patient relationship. Policy H-180.958, “Coverage of Prescription Contraceptives by Insurance,” supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives. Policy H-75.987, “Reducing Unintended Pregnancy,” urges health care professionals to provide care, assistance, and education for women of reproductive age, supports reducing unintended pregnancies as a national goal, and supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling. Policies H-75.985, “Access to Emergency Contraception,” and D-75.997, “Access to Emergency Contraception,” support the access to emergency contraception.

CONCLUSION

An FDA pathway exists for the conversion of prescription products, such as oral contraceptives, to OTC products if manufacturers submit the required application and data. A potential first candidate for an OTC progestin-only oral contraceptive product was recently announced by a manufacturer because progestin-only products have fewer contraindications than other types of oral contraceptives.

Research has shown that women support the idea of OTC oral contraceptives and can effectively self-screen for their use. Additionally, removing the prescription access barrier to oral contraceptives would increase and facilitate continuity of use. Full insurance coverage, without cost sharing, of an OTC oral contraceptive would likely result in the largest reduction of unintended pregnancies as well as cost effectiveness for insurers. However, concerns regarding
hindrance of overall access to oral contraceptives because of insurance formulary management strategies exist.

RECOMMENDATIONS

The Board of Trustees recommends the following be adopted in lieu of Resolution 110-A-17, and the remainder of the report be filed:


   Our AMA:
   1. Our AMA will recommend to the US Food and Drug Administration that manufacturers of oral contraceptives be encouraged to submit the required application and supporting evidence to the Agency to consider approving a switch in status from prescription to over-the-counter for such products.

2. Our AMA encourages the continued study of issues relevant to over-the-counter access for oral contraceptives. (Modify Current HOD Policy)


   Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.

   2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care. (Modify Current HOD Policy)

Fiscal Note: Less than $500
REFERENCES


Subject: In-Flight Emergencies  
(Resolution 516-A-17, Resolve 3)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee E  
(Douglas Martin, MD, Chair)

INTRODUCTION

At the AMA House of Delegates 2017 Annual Meeting, Resolve 3 of Resolution 516-A-17, “In-Flight Emergencies,” introduced by the Minority Affairs Section and referred by the House of Delegates (HOD), asked:

That our American Medical Association (AMA) support and advocate for a requirement that flight crews will no longer be required to verify a medical professional’s credentials before allowing that person to assist with an inflight medical emergency (IFME).

The original resolution explains that in instances of heart failure a lack of oxygen can cause brain damage in only a few minutes. “A person may die within 8 to 10 minutes and may experience cognitive deficits if deprived of oxygen for greater than 4 minutes.” Thus, the extra time it would take for flight staff to verify credentials of a passenger offering to render emergency medical assistance during an IFME could lead to a negative patient outcome.

This report will outline the current requirements concerning the verification of a medical professional’s credentials in the event of an IFME and existing AMA policies on physician identification of credentials and delivery of health care by Good Samaritans.

BACKGROUND

The Aviation Medical Assistance Act of 1998

Currently there is no federal law mandating that air carriers verify medical credentials or identification before allowing medical professionals to assist in emergency situations. The law only requires that air carriers believe in good faith that an emergency volunteer is medically qualified, in order to not be liable for damages arising out of the acts or omissions of the passenger (e.g., a physician passenger) rendering assistance of a passenger during an IFME. In relevant part, the Aviation Medial Assistance Act of 1998 states that:

SECTION 5. LIMITATIONS ON LIABILITY. (a) Liability of Air Carriers.--An air carrier shall not be liable for damages in any action brought in a Federal or State court arising out of the performance of the air carrier in obtaining or attempting to obtain the assistance of a passenger in an in-flight medical emergency, or out of the acts or omissions of the passenger
rendering the assistance, if the passenger is not an employee or agent of the carrier and the
carrier in good faith believes that the passenger is a medically qualified individual.

Online Forum

A comment on Resolution 516 was provided by a physician on the online forum. The commenting
physician expressed opposition to the resolution for a number of reasons. First, he drew from
personal experience and explained that a customary procedure already exists for a physician to
come forth with the appropriate medical documents before treating an individual. Next, he
explained that there are enough examples of individuals who attempt to act as a physician without
credentials to justify having a flight crew member verify identification in order to protect patients.
He also explained that credentialing should not be taken lightly. Lastly, he highlighted that most
commercial flights today have Wi-Fi capability and crews can easy and quickly check credentials
with state medical boards online. Note, the commenting physician interprets the requirement for
verification of a physician’s credentials as requiring either physical identification or by validation
through an online credential inquiry. As noted above, the law only requires good faith belief by an
air carrier that the passenger who volunteers to render assistance during an IFME is a medically
qualified individual. In practice, this could mean viewing physical identification or online
credentials or, could be achieved by requiring only a verbal statement by such passenger
concerning his or her credentials before allowing the passenger to provide assistance during an
IFME.

Relevant Current AMA Policy

Extensive AMA policies address IFMEs. Current AMA Policy H-45.997, “In-Flight Emergency
Care,” supports legislative provisions that grant any physician, other medical professional, or
airline employee, acting in the role of a Good Samaritan during an in-flight medical emergency, an
umbrella of immunity against legal or personal redress by the airline, the passengers, or the persons
involved in the medical emergency. Policy H-45.978, “In-Flight Medical Emergencies,” discusses
in-flight emergency medical supplies and equipment and implementation of comprehensive in-
flight emergency medical systems that ensure direct supervision by physicians with appropriate
training in emergency and aerospace medicine. Policy H-45.979, “Air Travel Safety,” encourages
actions to support education of physicians on available options if asked to render assistance during
an IFME to encourage full and effective participation when an IFME occurs.

In addition, there are existing AMA policies that address physician identification generally and
urges physicians to identify themselves by stating the full name of their certifying board. Note,
Policy H-405.987 only requires a verbal statement of credentials. Policy H-130.937, “Delivery of
Health Care by Good Samaritans,” describes basic guidelines to apply in instances where a
physician happens upon the scene of an emergency and desires to assist and render medical
assistance. Policy H-130.937 states, in part that it is the obligation of the bystander physician to
provide reasonable self-identification. This policy refers to situations in which a bystander
physician, parallel to an in-flight emergency physician, volunteers to provide emergency aid in
collaboration with EMS providers. While flight crews are not EMS providers or medical experts
this policy is instructive. Similar to the EMS team and physician, an in-flight physician and flight
crew may have to “work collaboratively” in assessing the medical emergency and providing
reasonable self-identification is appropriate. Note Policy H-130.937 only requires verbal or hand
signal verification of self-identification, not verification via physical identification or an online
credential inquiry.
CONCLUSION

Based on existing federal law (which does not require verification of medical credentials during an IFME), AMA policies described in this report, and industry guidelines on the topic of IFMEs and physician identification during medical emergencies, the Board of Trustees believes further efforts on this topic by our AMA are not necessary. It is reasonable for air carriers to determine the level and manner of verification of medical credentials (which could be achieved by a verbal statement) to establish a good faith belief that the passenger is a medically qualified individual before allowing a passenger to provide assistance during an IFME. This position would be consistent with existing AMA policies.

RECOMMENDATION

The Board of Trustees recommends existing AMA Policy H-45.979, “Air Travel Safety,” be reaffirmed in lieu of Resolve 3, Resolution 516-A-17, and the remainder of the report be filed.

Fiscal Note: Less than $500
REFERENCES

H-45.978, “In-Flight Medical Emergencies”
Our AMA urges: (1) urges that decisions to expand the contents of in-flight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; in-flight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure:

(a) rapid 24-hour access to qualified emergency medical personnel on the ground;
(b) at a minimum, voice communication with qualified ground-based emergency personnel;
(c) written protocols, guidelines, algorithms, and procedures for responding to in-flight medical emergencies;
(d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form;
(e) adequate medical supplies and equipment aboard aircraft;
(f) routine flight crew safety training;
(g) periodic assessment of system quality and effectiveness; and
(h) direct supervision by physicians with appropriate training in emergency and aerospace medicine.

H-45.979, “Air Travel Safety”
Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and (3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar.

H-130.937, “Delivery of Health Care by Good Samaritans”
1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
2. Our AMA encourages state medical societies in states without "Good Samaritan laws," which protect qualified medical personnel, to develop and support such legislation.
3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician
to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.

4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.
INTRODUCTION

At the 2017 Annual Meeting, Resolution 508-A-17, “Support for Service Animals, Emotional Support Animals, Animals in Healthcare, and Medical Benefits of Pet Ownership,” introduced by the Medical Student Section and referred by the House of Delegates (HOD), asked:

That our AMA (1) recognize the potential medical benefits of animal-assisted therapy and animals as companions; and (2) encourage research into the use and implementation of service animals, emotional support animals and animal-assisted therapy as both a therapeutic and management technique of disorders and handicaps when expert opinion and the scientific literature show a potential benefit.

Considerable confusion exists in differentiating service animals, emotional support animals (ESAs), and companion animals as well as the role of animals in animal-assisted therapy (AAT). This report will define the different categories of assistance animals and outline the current landscape of evidence related to the use of animals in medical treatments.

BACKGROUND

Lack of clarity and confusion exist regarding the terms used to designate the function and role of animals used for emotional support, comfort, and therapy. Individuals with disabilities may use animals for a variety of reasons, so a clear vocabulary is necessary to advance the science and communicate findings across these disciplines.1

Differentiating factors in the categorization of animals include: 1) the animal’s ability to provide assistance that is related to an individual’s disability; 2) whether assistance or support provided by the animal requires either a basic or advanced skill level (basic skills are synonymous with simple obedience while advanced skills are more complex or specialized tasks); and 3) whether a public service, military, or healthcare professional uses the animal to assist in the implementation of a specific public service task or health-related treatment plan (the primary care-giver for the animal is not the person with the disability).
CATEGORIES OF ASSISTANCE ANIMALS

Service Animal

As defined by Title II and Title III of the Americans with Disabilities Act (ADA), a service animal is a dog (or in some circumstances, miniature horse) “that is individually trained to do work or perform tasks for the benefit of an individual with a disability including a physical, sensory, psychiatric, intellectual, or other mental disability.” The work or tasks performed by a service dog must be directly related to the individual’s disability and that individual is the primary handler and care-giver of the animal. The ADA definition specifically excludes dogs whose sole function is to provide comfort or emotional support. Service animals have broad access to public locations, but access may be prohibited when their presence results in changes to normal business practice or when their presence poses health or safety risks.2 These animals have an advanced level of training and nationally-recognized certification programs are available but not mandated.1,3 Service dogs receive up to two years of training, and can cost more than $40,000. Current demand exceeds availability, and some individuals may wait for several years. The primary care-giver of the dog is often required to live at a training center for a period of time to receive training as well. Guide dogs, autism dogs, psychiatric service dogs, and diabetic alert dogs are examples of trained service animals. Other species of animals, either domestic trained or untrained, are not considered service animals.

During air travel, the Air Carrier Access Act protects the rights of passenger with disabilities and must permit a service animal to accompany a passenger with a disability. Identification cards, other written documentation, presence of harnesses, tags, or the credible verbal assurances of a qualified individual with a disability using the animal qualify as evidence that the animal is a service animal.4

Public Service or Military Animal

Public service or military animals have been trained in advanced skills to provide work or tasks to assist public service or military professionals in performing their duties.1 Cadaver dogs, search-and-rescue dogs, and police dogs are examples of public service animals.

Therapy Animals

Therapy animals are trained in either basic or advanced skills to assist a healthcare professional qualified within the scope of a therapeutic treatment plan. These animals are used by professionals for AAT to help their patients or clients achieve treatment goals. The therapy is conducted under the guidance of a responsible healthcare professional and the treatment is conducted according to accepted practices and ethical principles, which include adequate training of the professional to work with the animal.1 Therapy animals have limited access to public locations and are often under the care of the professional who oversees the AAT. The patient receiving the AAT is not the care-giver of the animal.

Visitation Animals

Visitation animals are trained in basic skills to provide comfort and support to individuals through companionship and social interaction primarily in nursing homes, hospitals, and schools.1 Visitation animals are not required to be accompanied by healthcare professionals and are usually handled and owned by community volunteers.1
Emotional Support Animals

ESAs provide physical, psychiatric, or emotional support to individuals primarily in their home. No standards exist for the training of ESAs, which usually have only basic obedience skills because they are primarily owned pets.\(^1,3\) ESA access to public locations is limited. Their rights are governed by the Fair Housing Act of 1988 (FHA) which states that ESAs can reside in both public and private housing with proof of need for an ESA. Under Federal Department of Housing and Urban Development regulations, an animal qualifies as a support animal if an individual has a disability, an animal is needed to assist with a disability, and the individual demonstrates that there is a relationship between the disability and the assistance that the animal provides.\(^1\) Proof of need is most easily, and often, conveyed with a letter from a physician describing the necessity of an animal to a person’s specific disability. Of note and according to the ADA, a letter from a physician stating the person has a disability and needs an animal for emotional support does not mean that animal qualifies as a service animal.\(^2\)

According to federal regulations, airlines are not required to accept ESAs unless passengers provide current documentation on the letterhead of a licensed mental health professional (e.g., psychiatrist, psychologist, licensed clinical social worker, including a medical doctor specifically treating the passenger's mental or emotional disability) stating: 1) the passenger has a mental or emotional disability recognized in the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM IV); 2) the passenger needs the ESA as an accommodation for air travel and/or activity at the passenger's destination; 3) the individual providing the assessment is a licensed mental health professional, and the passenger is under his or her professional care; and 4) the date of the documentation and the mental health professional's license information.\(^4\)

No certification or registration standards exist for ESAs; however, many online agencies claim to "register" an ESA for a fee, offer identification cards, kits with identification vests, and some provide healthcare professional letters for a fee.\(^5-8\) The industry that has developed around the certification of ESAs to allow pet owners to have their animals with them in restricted housing and on flights at no cost has raised concerns from both professional and ethical standards perspectives.\(^9\)

SERVICE ANIMAL AND EMOTIONAL SUPPORT ANIMAL POLICY

The recent proliferation of service dogs and ESAs has led to individuals taking advantage of unclear policies and misrepresenting animals as service animals.\(^3\) The ADA permits only two questions to be asked of people with service animals: 1) Is the dog a service animal and 2) what task is the dog trained to perform? No additional inquiry can be made regarding a disability, and no proof of service dog status can be requested. No federal licenses or documents to prove service dog status exist, but some states do have "assistance animal" registries for service dogs with the intended purpose of making access to public places easier for the animal and handler.\(^10\) A recent study of assistance dog registrations in California revealed that registrations have increased sharply in the past decade and that tags have been mistakenly issued to ESAs, some cats, and dogs not fitting the definition of assistance dogs under the law.\(^11\)

Although there is substantial variation in scope and penalty, nineteen states have laws against the fraudulent representation of a service animal.\(^12,13\) Other states are considering legislation against fraudulent ESAs.\(^13,14\) Furthermore, proposed federal legislation amending the Air Carrier Access Act includes ESAs in the definition of service animals.\(^15\)

True service dogs are essential for the well-being of their human owners and both humans and the service dogs are put at risk by untrained dogs in public places. Advocates for laws against service
dog fraud, as well as responsible pet owners, have voiced opinions that new legislation should include public education efforts on legitimately trained service dogs and the distractions imposed by untrained pets and the need for a national certification program and registry for legitimately trained service dogs.13,16

Few studies have addressed the public health risks of animals in the healthcare setting and the limited research that has been conducted indicates cause for concern. For example, methicillin-resistant Staphylococcus aureus (MRSA) has increasingly been described in cats and dogs making these animals a potential source of MRSA exposure in healthcare facilities.17 In a survey of U.S. hospitals, elder care facilities, and therapy animal organizations, health and safety policies for therapy animals varied significantly and many did not follow recommended guidelines for animal visitation, potentially compromising human and animal safety.18,19

EVIDENCE RELATED TO THE USE OF ANIMALS IN MEDICAL TREATMENTS

Limited evidence exists regarding the use of animals for treatments of individuals. Evidence of benefits of AAT and animals as companions is limited in depth because the sample sizes of the few clinical trials are either too small to produce reliable results or there is little evidence that the improvement is due to the presence of the animal as opposed to interacting with the animals’ sympathetic handlers. Additionally, study authors note the need for longitudinal follow-up studies to verify the stability of a therapeutic effect attributed to the AAT on the patients. Of the limited and relatively low quality randomized controlled trials identified, approximately half involved “mental and behavioral disorders” and the types of animal interventions included dog, cat, dolphin, bird, cow, rabbit, ferret, and guinea pig.20-25 Numerous examples of individual case studies and individual clinical anecdotes exist in the literature.26

The American Veterinary Medical Association (AVMA) and others have researched the benefits of pet ownership and maintain resources detailing the work.27-29 The Human-Animal Bond Research Initiative (HABRI) Foundation and the Purdue University College of Veterinary Medicine maintain an online platform for open research and collaboration regarding the relationships between humans and their pets.30

CURRENT AMA POLICY

AMA policy does not address the use of AAT or companion animals, but broadly addresses alternative treatments. Current AMA Policy H-480.964, “Alternative Medicine,” addresses alternative therapies and states research should be done to evaluate efficacy; physicians should routinely inquire and educate themselves and their patients about alternative therapies; and that patients should be educated about any potential hazards of stopping conventional medical treatment. Policy H-295.902, “Alternative Medicine,” states that medical school courses addressing alternative medicine should present the scientific view of unconventional therapies, potential therapeutic utility, safety, and efficacy.
RECOMMENDATIONS

The Board of Trustees recommends the following policy be adopted in lieu of Resolution 508-A-17, and the remainder of the report be filed:

Service Animals, Animal-Assisted Therapy, and Animals in Healthcare

Our American Medical Association:

1. Encourages research into the use of animal-assisted therapy as a part of a therapeutic treatment plan.
2. Supports public education efforts on legitimately trained service animals, as defined by the Americans with Disabilities Act (ADA).
3. Supports a national certification program and registry for legitimately trained service animals, as defined by the ADA.
4. Encourages health care facilities to set evidence-based policy guidelines for animal visitation. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES


REPORT OF THE BOARD OF TRUSTEES

B of T Report 30-A-18

Subject: In-Flight Emergencies (Resolution 516-A-17, Resolve 5)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee E
(Douglas Martin, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting, Resolve 5 of Resolution 516-A-17, “In-Flight Emergencies,” introduced by the Minority Affairs Section and referred by the House of Delegates (HOD), asked:

That our American Medical Association (AMA) offer medical trainees and physicians medical education courses to prepare for addressing in-flight emergencies during its meetings and/or by strongly encouraging its affiliated state and local branches to offer similar education courses.

This report will outline the current options for physician continuing medical education (CME), guidance, and policy on the topic of in-flight medical emergencies (IFMEs).

BACKGROUND

IFMEs are defined as medical events that require the attention of medical professionals or the flight staff and crew aboard an aircraft. These emergency events occur in about one out of every 604 flights, but the actual incidence of these events is unknown and this is likely an underestimate because of underreporting.¹ The most common medical emergencies are feelings of lightheadedness and dizziness, acute infections, shortness of breath, trauma, syncope, altered mental status, stroke, and acute coronary syndromes.¹

ON-BOARD MEDICAL RESOURCES

The Federal Aviation Administration (FAA) mandates that U.S.-based airlines carry first aid kits that are stocked with basic supplies such as bandages and splints. The requirements were arrived at based on public input during a Notice of Proposed Rulemaking included in the Aviation Medical Assistance Act of 1998. At least one kit must contain the required items, and at least one automated external defibrillator (AED) must be available.² For international airlines, medical supply requirements are determined by the corresponding national aviation regulatory authority in collaboration with the airlines they regulate.

Ground-based medical support systems (GBMS) are widely used by airlines, especially by long haul aircraft, to provide advice to crew who are dealing with a medical emergency. The ground based medical officer can provide advice to crew and to an on board volunteer doctor since he/she is trained in the provision of aircraft related medical advice, knows exactly what is contained in a particular operator’s on board medical supplies and is aware of the medical facilities in the vicinity of the aircraft, should a diversion need to be considered.
AIRLINE PROTOCOLS FOR MANAGING IN-FLIGHT MEDICAL EVENTS

When in an aircraft, the pilot, assisted by the co-pilot, has overall responsibility for the passengers, the crew, the flight, and the aircraft. Cabin crews, who are responsible for managing IFMEs are trained to recognize common medical issues and provide first aid and basic cardiopulmonary resuscitation. Cabin crew will generally make an initial assessment of a passenger in need of medical assistance and will keep the pilot informed about the situation. Crew is also responsible for requesting assistance from any onboard medical professionals if needed. The pilot can call GBMS for assistance if necessary.

IFME GUIDANCE, TRAINING, AND POLICY

Congress passed the Aviation Medical Assistance Act in 1998, which protects providers who respond to IFMEs. Onboard emergency medical equipment, including automated external defibrillators (AEDs) and emergency medical kits are federally regulated; minimum emergency medical kit requirements exist and AEDs are required on all airplanes of air carriers operating under CFR part 121 with a maximum payload capacity of more than 7,500 pounds and with at least one flight attendant.

The Aerospace Medical Association (AsMA) has done extensive work to address IFMEs. With the collaboration of other medical organizations, including the AMA, AsMA released a guidance document with information and/or recommendations about what the most common IFMEs are, how often they occur, necessary on-board medical supplies, appropriate cabin crew training, the need for automated external defibrillators, and legal aspects of IFMEs. In April 2016, AsMA convened an Aircraft Emergency Medical Kits Workgroup that included AMA representation. Based on the outcome of this meeting, AsMA further refined its recommendations regarding medical guidelines for airline travel/in-flight medical care, including the contents of on-board medical supply kits. These recommendations support an expanded cache of supplies compared with those required by the FAA. The AsMA guidance also includes information to assist volunteer medical professionals who respond to a request for medical assistance, including advice on providing identification and proof of credentialing, inquiring about ground support, and documenting diagnostic findings and treatment.

In collaboration with the AMA, International Civil Aviation Organization (ICAO), International Air Transport Association (IATA), International Academy of Aviation and Space Medicine (IAASM), American Osteopathic Association (AOA), and American College of Emergency Physicians (ACEP), AsMA also has developed an educational and training resource document for health professionals entitled, “Managing In-flight Medical Events.”

Other aviation organizations also regularly study, make recommendations on, and have informational material related to IFMEs. IATA publishes a medical manual which details protocols for IFMEs. ICAO works in close collaboration with agencies and organizations including the World Health Organization (WHO), IATA, and Airport Council International (ACI) to provide medically related publications, training, and policy. ICAO also cooperates and consults with the chief medical officers of civil aviation authorities around the world and the Medical Directors of airline companies.

Recently, a CME opportunity on the topic of IFMEs was published in the Cleveland Clinic Journal of Medicine.
CURRENT AMA POLICY

Extensive AMA policies address IFMEs. Policy H-45.979, “Air Travel Safety,” (Appendix) supports efforts to educate the flying physician public about IFMEs to help them participate more fully and effectively when an IFME occurs. Policy H-45.978, “In-flight Medical Emergencies,” discusses in-flight emergency medical supplies and equipment and H-45.982, “Improvement in U.S. Airlines Aircraft Emergency Kits,” urges the FAA to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices.

SUMMARY AND CONCLUSION

Although numerous publications of experiences managing IFMEs exist in the literature, many are anecdotal, based on one event, and may draw conclusions that are not necessarily applicable throughout the industry. AsMA, in collaboration with several other organizations, has developed guidance and training for medical practitioners who volunteer to provide assistance on board an aircraft. Additionally, other resources are available to physicians interested in learning more about IFMEs. Resources available on the topic of IFMEs include:

- AsMA guidance document
- IATA medical manual
- Cleveland Clinic Journal of Medicine CME
- In-Flight Medical Emergencies during Commercial Travel, New England Journal of Medicine article detailing response recommendations, consulting with GBMS, and medical kit contents
- ICAO information regarding Aviation Medicine
- Handling In-Flight Medical Emergencies
- What to do during inflight medical emergencies? Practice pointers from a medical ethicist and an aviation medicine specialist.
- FAQ: What Should Happen During an Inflight Medical Emergency

Given that up-to-date educational resources are available on this topic, the Board of Trustees believes further efforts on this topic by our AMA are not necessary at this time. The extensive work by AsMA and others, as well as current AMA policy, address IFMEs in depth.

RECOMMENDATION

The Board of Trustees recommends the existing AMA Policy H-45.979, “Air Travel Safety,” be reaffirmed in lieu of Resolve 5, Resolution 516-A-17, and the remainder of the report be filed. (Reaffirm Current HOD Policy)

Fiscal Note: Less than $500
REFERENCES


APPENDIX

Policy for Reaffirmation

H-45.979, “Air Travel Safety”

Our AMA:

(1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies;

(2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and

(3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 38-A-18

Subject: Timely Referral to Pain Management Specialist (Resolution 714-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee E
(Douglas Martin, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 714-A-17, “Timely Referral to Pain Management Specialist,” for report back at the 2018 Annual Meeting. This resolution was introduced by the Michigan Delegation and asked that:

Our American Medical Association (AMA) urge the Centers for Medicare & Medicaid Services (CMS) and the Medicare Contractor Advisory Committee to endorse and adopt evidence-based clinical practice guidelines on the management and treatment of pain including but not limited to timely and appropriate referral to pain management specialists.

During the hearing on this resolution, Reference Committee G heard mixed testimony. The majority of testimony on Resolution 714 opposed mandating that physicians should refer patients to pain management specialists. Testimony also noted the lack of access to pain management specialists in many communities, in addition to long waiting times to see pain specialists, making timely referrals to see these specialists problematic. This report discusses whether the AMA should urge CMS to adopt clinical practice guidelines on the management and treatment of pain.

BACKGROUND

Existing AMA Policies


These policies note AMA’s support for health insurance coverage that gives patients access to the full range of evidence-based chronic pain management. In addition, existing policies state the AMA’s support for efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services.

Furthermore, existing AMA policy states that the AMA “will work to ensure that interventional pain management is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence,” Policy H-410.958. There is further existing AMA
policy which states that the AMA “will support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management,” Policy D120.976.

Existing Clinical Practice Guidelines

Numerous clinical practice guidelines exist on the management and treatment of pain, including from the American Academy of Pain Medicine, the American Pain Society, the American College of Emergency Physicians, and American College of Physicians.¹

DISCUSSION

Clinical Practice Guidelines Developed by Specialties

Resolution 714-A-17 asks the AMA to urge CMS to endorse and adopt evidence-based clinical practice guidelines. However, to do so would be generally inconsistent with current AMA policy. The AMA has historically supported the development of clinical practice guidelines from specialty societies as opposed to CMS or other federal government entities. We believe that specialty societies are better positioned to consult with an array of physicians within a given specialty, and that physicians, rather than CMS, should take the lead on the development of clinical practice guidelines.

In addition, numerous clinical practice guidelines already exist from specialty societies whose physicians handle the management and treatment of pain, including the American Academy of Pain Medicine, the American Pain Society, and the American College of Emergency Physicians. If a physician wishes to refer to clinical practice guidelines on managing and treating pain, there are numerous existing guidelines to consult.

Referral to Pain Management Specialist

Resolution 714-A-17 would call on the federal government to set a standard that physicians should refer patients to pain management specialists. However, AMA policy recognizes that it is not always necessary for patients with pain to be referred to a pain management specialist. In addition, many communities do not have access to pain management specialists or have long waiting times to see pain management specialists, making timely referrals to see these specialists problematic.

Modification of Existing AMA Policy

The adoption of Resolution 714-A-17 would not be consistent with the plethora of existing AMA policy for the reasons stated above. However, the Board of Trustees believes that existing AMA policy should be amended to state more succinctly the AMA’s support for efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, with a focus on achieving improvement in function and activities of daily living. Existing policy should also be amended to document the AMA’s position that guidance on pain management should be developed by the specialties who manage these conditions.
RECOMMENDATION

The Board of Trustees recommends that Policy H-185.931 be amended by addition and deletion in lieu of Resolution 714-A-17 and the remainder of the report be filed:

Policy H-185.931, “Coverage for Chronic Pain Management”

1. Our American Medical Association (AMA) supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options when appropriate, with a focus on achieving improvement in function and activities of daily living.

2. Guidance on pain management for different clinical indications should be developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.

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

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

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

(Modify Current HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


APPENDIX – CURRENT AMA POLICY

**Policy H-185.931, “Coverage for Chronic Pain Management”**

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

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

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

**Policy H-410.958, “Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers”**

Our AMA: (1) encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that interventional pain management of patients suffering from chronic pain constitutes the practice of medicine; and (2) will work to ensure that interventional pain management is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in pain management and palliative care offered by nursing programs and medical schools in order to demonstrate adherence to current standards in pain management.

**Policy H-410.950, “Pain Management”**

Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post-operative course of care. Invasive pain management techniques include:

1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic discectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia. When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.

**Policy D-120.976, “Pain Management”**
Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain).

**Policy D-160.981, “Promotion of Better Pain Care”**
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.
2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages.

4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.

5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.
REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-18)
Drug Shortages: Update
(Reference Committee E)

EXECUTIVE SUMMARY

Objective. This report updates information on drug shortages since the 2017 report was developed, specifically commenting on the increase in drug shortages due to hurricanes that have impacted the pharmaceutical industry in Puerto Rico as well as other relevant policy considerations regarding manufacturer processes recently brought to light which have implications for the United States health care system.

Methods. English-language reports were selected from a PubMed and Google Scholar search from September 2016 to February 2018, using the text term “drug shortages” combined with “impact,” “crisis,” “oncology,” “chemotherapy,” “antibacterial,” “pediatric(s),” “nutrition,” and “parenteral.” Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the US Food and Drug Administration (FDA), American Society of Health-System Pharmacists (ASHP), Pew Charitable Trusts, the Association for Accessible Medicines, the Pharmaceutical and Research Manufacturers of America (PhRMA), the Institute for Safe Medication Practices (ISMP), and by direct contact with key FDA, ASHP, and Utah Drug Information Service staff who monitor drug shortages and related issues on a daily basis. A recent roundtable report developed by ASHP also was consulted as a key resource.

Results. Drug shortages remain an ongoing public health concern in the United States and the FDA and ASHP continue to provide information regarding the topic. Although the rate of new shortages has decreased, long-term active and ongoing shortages are not resolving and critical shortages are impacting patient care and pharmacy operations. In late 2017, major hurricanes struck Puerto Rico which houses significant infrastructure for manufacturing critical pharmaceutical and other medical products. The FDA has issued multiple statements regarding the situation in Puerto Rico and has undertaken extensive efforts to avoid exacerbating critical drug shortages. In November 2017, AMA took part in an ASHP-convened meeting to review and identify new opportunities to address ongoing supply chain and patient-care challenges associated with drug product shortages. Eleven recommendations were crafted as a result of discussions at the roundtable.

Conclusion. Although recent natural disasters have increased the number of drug shortages only slightly, shortages of basic products such as saline and small-volume parenteral solutions, and their containers, are significantly impacting the health care system by affecting patient care, increasing the potential for drug errors, and influencing the manner in which health care teams function. Information and discussion at an ASHP-convened roundtable on current issues regarding drug shortages illuminated additional relevant policy considerations such as manufacturer transparency regarding production location and the cause(s) of shortages; quality of outsourcer compounding facilities; and the potential inclusion of vital drug manufacturing sites as critical infrastructure.
Subject: Drug Shortages: Update

Presented by: Robert A. Gilchick, MD, Chair

Referred to: Reference Committee E (Douglas Martin, MD, Chair)

INTRODUCTION

American Medical Association (AMA) Policy H-100.956, “National Drug Shortages,” directs the Council on Science and Public Health (CSAPH) to continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue.

METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2016 to February 2018, using the text term “drug shortages” combined with “impact,” “crisis,” “oncology,” “chemotherapy,” “antibacterial,” “pediatric(s),” “nutrition,” and “parenteral.” Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the US Food and Drug Administration (FDA), American Society of Health-System Pharmacists (ASHP), Pew Charitable Trusts, the Association for Accessible Medicines, the Pharmaceutical and Research Manufacturers of America (PhRMA), the Institute for Safe Medication Practices (ISMP), and by direct contact with key FDA, ASHP, and Utah Drug Information Service staff who monitor drug shortages and related issues on a daily basis. A recent roundtable report developed by ASHP also was consulted as a key resource.

BACKGROUND

The CSAPH has issued eight reports on drug shortages. The findings and conclusions of the first five reports are summarized in CSAPH Report 2-I-15, “National Drug Shortages: Update.” The remainder of this report will update information on drug shortages since the 2017 report was developed, specifically commenting on the increase in drug shortages due to hurricanes that have impacted the pharmaceutical industry in Puerto Rico as well as other relevant policy considerations regarding manufacturer processes recently brought to light which have implications for the United States health care system.

CURRENT TRENDS IN DRUG SHORTAGES

Drug shortages remain an ongoing public health concern in the United States. Although the rate of new shortages has decreased, long-term active and ongoing shortages are not resolving and critical shortages are impacting patient care and pharmacy operations. Several commonly used products
required for patient care are in shortage including sterile infusion solutions (e.g., saline, amino
ci1 acids, dextrose), as well as diazepam, lidocaine, hydromorphone, and morphine.10-12

Ongoing supply challenges of certain medications, typically injectable products that are off-patent
and have few suppliers, persist. Causes of these shortages continue to remain largely unchanged
and are mostly triggered by quality problems during manufacturing processes.

As noted in previous Council reports, the two primary data sources for information on drug
shortages in the United States continue to be the Drug Shortage Program at the FDA and the Drug
Shortage Resource Center maintained by ASHP in cooperation with the University of Utah Drug
Information Service. According to the most recent data compiled by ASHP and the University of
Utah Drug Information Service, the total number of new shortages in 2017 was 146 (compared
with 154 in 2016) and the number of active shortages was 183 in quarter four of 2017. As of the
end of 2017, the largest number of shortages belongs to the class of electrolytes, nutrition, and
fluids; for 3% of the shortages, the reported reason was “natural disaster” (Appendix). The most
recent metrics reported by the FDA are listed in the 2017 Drug Shortages: Update report.9 Updated
metrics from the FDA are anticipated in summer of 2018.

The FDA continues to utilize a mobile app to provide up-to-date access to drugs in shortage as well
as notifications about new and resolved drug shortages and ability for physicians to report a drug
shortage (Box 1). The ASHP drug shortage resource center provides a list of shortages and some
guidance on managing critical shortages (Box 1).

STATE OF THE INDUSTRY

The U.S. Government Accountability Office (GAO) examined shortages of sterile injectable anti-
infective and cardiovascular drugs in 2012, 2013, and 2014 and noted that the shortages were
strongly associated with three factors:

1. A decline in the number of suppliers
2. Failure of at least one establishment making a drug to comply with manufacturing
   standards resulting in a warning letter
3. Drugs with sales of a generic version

These factors suggest that shortages may be triggered by supply disruptions and by market forces
in which there are low profit margins for generic drugs, resulting in manufacturers being less likely
to increase production.11

Legislation enacted in 2012, the Food and Drug Administration Safety and Innovation Act (Title X:
Drug Shortages) (FDASIA) requires drug manufacturers to notify the U.S. Food and Drug
Administration (FDA) “of any change in production that is reasonably likely to lead to reduction in
supply” of a covered drug in the United States. Although this warning requirement has played a
significant role in reducing the number of drug shortages, it has not solved the problem.13

Impact of Hurricanes Irma and Maria on Drug Manufacturing in Puerto Rico

In late 2017, major hurricanes struck Puerto Rico which houses significant infrastructure for
manufacturing critical pharmaceutical and other medical products for worldwide distribution,
including the United States. The FDA has issued multiple statements regarding the manufacturing
situation in Puerto Rico. Extensive efforts have been undertaken to avoid exacerbating critical drug
shortages and addressing challenges related to refrigeration, storage and transportation. FDA also
has been working to relocate production in coordination with federal and local government
colleagues and pharmaceutical companies. Additionally, the agency is paying particularly close
attention to the demand for empty containers, which are also produced on the island, as an alternative to filled infusion bags.\textsuperscript{14,15}

A primary concern is the shortage of small-volume parenteral solution (SVP) products, including saline, due to production and supply-chain problems on the island. ASHP and the University of Utah Drug Information Service have developed a clinical resource on the conservation and management of SVPs (Box 1).\textsuperscript{16} Additionally, emergency physicians from Brigham and Women’s Hospital recently published an oral rehydration protocol for use to conserve sterile infusion fluids.\textsuperscript{17}

ASHP DRUG SHORTAGES ROUNDTABLE

In November 2017, AMA took part in an ASHP-convened meeting to review and identify new opportunities to address ongoing supply chain and patient-care challenges associated with drug product shortages. The meeting served as a forum for several health care organizations to examine how FDASIA has impacted shortages and to address whether a need exists to build on the law with new recommendations.

FDA Drug Shortage Program Update

An update provided by staff from the FDA Drug Shortage Program confirmed that the notification requirement enacted as part of FDASIA is generally being followed and that most companies report to the agency when they anticipate or experience problems that may lead to a shortage. A few companies have failed to comply with reporting requirements suggesting the need for additional manufacturer education regarding their reporting responsibility. Timely notification enables the FDA to create solutions intended to prevent the onset of a shortage (e.g., work with other manufacturers behind the scenes to ramp up production, expedite the review of an abbreviated new drug application (ANDA) from another company, develop a work around for the production issue, or begin the process of controlled importation of a drug to meet demand). FDA staff reiterated that the requirement for manufactures to notify the FDA does not obligate them to disclose the problem for the interruption, its expected duration, or an estimated time frame for resolution. Additionally, under current US law, the agency cannot require a company to manufacture a drug, no matter how critical or life-sustaining it is.

While the FDA encourages companies to develop drug shortage contingency plans, few have them. More could be done to incentivize companies to develop such plans and establish manufacturing redundancy.

Outsourcer Compounding Facilities

In 2013, legislation was enacted to provide more regulatory oversight of compounding. The law created a new category of compounder, an outsourcing facility, which is regulated under Section 503B of the Food, Drug and Cosmetics Act. This category allows firms that compound drugs without a patient-specific prescription to be licensed and inspected by the FDA rather than the state board of pharmacy. These firms are not classified as pharmacies but more closely resemble drug manufacturers in their operation.

Several issues were discussed at the roundtable regarding 503B facilities and their ability to provide specific formulations in the event of drug shortages. It can take up to six weeks for 503B facilities to increase or begin production of a drug in shortage and they can do so only after the FDA adds the product to the shortage list. Because the products in short supply and the duration of the shortage cannot be predicted, not only can delays exist in initiating production, but inconsistent
fulfillment from 503B facilities is common. Additionally, many 503B facilities are not able to
produce drugs from active pharmaceutical ingredients (APIs) and only repackage other
commercially available formulations. Adding to this complication, 503B facilities currently cannot
repackage SVPs because the empty bags needed to do so are also in shortage.

Several 503B outsourcing facilities have been issued an FDA Form 483, the FDA inspection
review form issued to manufacturers at the conclusion of an inspection when an investigator(s) has
observed any condition that may constitute a violation of the Food Drug and Cosmetic (FD&C) Act
and related Acts. However, no additional information is posted if or when a facility successfully
addresses the deficiency detailed in the report. The uncertainty surrounding manufacturing quality
among these facilities creates uncertainty for hospitals that may choose to rely on them to mitigate
drug shortages.

Drug Manufacturing as Critical Infrastructure

The term “critical infrastructure” is defined in the USA Patriot Act of 2001 as “systems and assets,
whether physical or virtual, so vital to the United States that the incapacity or destruction of such
systems and assets would have a debilitating impact on security, national economic security,
national public health or safety, or any combination of those matters.” Flowing out of Presidential
Policy Directive 21 (PPD-21), titled Critical Infrastructure Security and Resilience, was the
drafting of an update to the National Infrastructure Protection Plan (NIPP), published by the
Department of Homeland Security (DHS). This update, titled NIPP. 2013, describes a national
effort to identify and achieve critical infrastructure security and resilience and manage risk through
partnership efforts and information sharing between public and private organizations. Because the
United States critical infrastructure is largely owned by the private sector, managing risk to
enhance security and resilience needs to be a shared priority for industry and government. The
Healthcare and Public Health (HPH) Sector-Specific Plan (SSP) tailors the strategic guidance
provided in the NIPP to the unique operating conditions and risk landscape of the HPH sector.
The HPH SSP outlines how public and private sector partners will evaluate risks; coordinate plans
and policy; and provide guidance to prevent, protect, mitigate, respond to, and recover from all
hazards that pose a threat to the HPH sector critical infrastructure.

At the roundtable, the Office of the Assistant Secretary for Preparedness and Response (ASPR),
Office of Emergency Management, part of the U.S. Department of Health & Human Services
(DHHS), outlined its efforts to coordinate with DHS and public and private sector organizations
involved in disaster response. The DHS list of critical infrastructure, which includes the HPH
sector, and criteria for determining the vulnerability of the infrastructure, may be re-examined in
the near future; the current plan has very specific parameters and few are HPH-related.

The discussion with ASPR focused on the potential for evaluating manufacturer locations and their
cybersecurity as criteria for determining risk and inclusion within the list of critical infrastructure.
The fact that several manufacturers were impacted by cyber events over the past year and that
product shortages were worsened by the recent hurricanes impacting Puerto Rico, highlight the
need to evaluate risk and hazard and disaster response for drug and medical product manufacturing.
However, production location for specific drugs and other medical products is proprietary
information and many manufacturers are unwilling to share this with DHHS and/or DHS. ASPR
wants to work more closely with manufacturers and explain the benefits of information sharing and
being included as critical infrastructure. Of note is that any information shared with DHS or DHHS
is, by law, protected from public disclosure and used only in the context of preparedness planning
and response. Additionally, DHHS in collaboration with DHS can provide analytical tools to help
manufacturers prepare for disasters, identify their dependencies such as power and water, and
become more resilient.

Automation Difficulties

Many of the drugs currently in shortage are basic products required for patient care in all medical
settings, such as saline and SVPs. Shortages of these basic products, and their containers, are
significantly affecting patient care and healthcare providers because options to address these
shortages are limited or risky.

Increasing automation and the use of informatics in hospitals and large healthcare centers has
created efficiencies, but the use of devices such as infusion pumps and the utilization of electronic
health records (EHRs) can be associated with problems in the case of drug shortages. Many devices
are often designed to use specific products from specific manufacturers. When the required product
is not available and alternatives must be used, it is burdensome and requires significant work to
change parameters for device functionality, if it is possible at all. Many EHRs have specific drugs
and doses prepopulated for streamlining patient care and care team collaboration. When shortages
occur and other drugs or doses are the only options available, EHRs must be reprogrammed with
the new options, often at each EHR station and for each patient individually.

Recommendations Resulting from the Roundtable

Eleven recommendations were crafted as a result of discussions at the roundtable (Box 2). Some of
them are already reflected in current AMA policy on drug shortages including urging
manufacturers to establish contingency plans or redundancies in production and requiring FTC
review of manufacturer mergers to evaluate shortage risk. Other recommendations include a call
for greater manufacturer transparency, more information on the quality of outsourcing
compounding facilities, and the examination of drug shortages as a national security initiative
resulting in the addition of vital manufacturing sites as critical infrastructure.

IMPACT OF SHORTAGES ON HEALTH CARE PRACTICE

ISMP Practices Survey

ISMP recently published the results of a drug shortage survey they conducted in late 2017, before
natural disasters exacerbated the shortage problem. Almost all respondents of the survey
practiced in a hospital setting. Shortages were reported across all treatment categories.
Approximately 55% of respondents indicated experiencing shortages involving more than 20 drugs
within the last six months and most (66%) were affected by at least one shortage daily.

The survey results revealed concerning trends:
- Approximately 90% of respondents experienced rationing, restricting, and hoarding of
drug supplies.
- Many commented on waste (for example, 250ml bags of insulin but only a small fraction is
needed).
- Survey participants noted other strategies that are being employed including re-deploying
medications used for crash carts, reusing vials, extending hang times for IVs, purchasing
sterile products compounded from non-sterile ingredients from compounding pharmacies
without evaluating the risk, and transitioning infusion devices to push IVs (changing nurse
protocols).
15% admitted to purchasing drugs in short supply at great cost from a secondary gray market.

Most survey participants (71%) were unable, at times, to provide patients with the recommended drug or treatment for their condition due to shortages, which resulted in patients receiving a less effective drug and delayed treatments. Many participants also stated that they need full-time staff to manage drug shortages and commented that the tasks associated with this process reduce the time available for direct patient care. Additionally, many respondents provided examples of how recent drug shortages have led to unsafe practices that have increased the risk of, or contributed to, a medication error.

SUMMARY

Although recent natural disasters have increased the number of drug shortages only slightly, shortages of basic products such as saline and SVPs, and their containers, are significantly impacting the health care system by affecting patient care, increasing the potential for drug errors, and influencing the manner in which health care teams function. Box 1 is a compilation of resources available to assist physicians and hospitals in mitigating drug shortages.

Information and discussion at an ASHP-convened roundtable on current issues regarding drug shortages illuminated additional relevant policy considerations such as manufacturer transparency regarding production location and the cause(s) of shortages, quality of outsourcer compounding facilities, and the potential inclusion of vital drug manufacturing sites as critical infrastructure.

Given its role as the leading advocacy organization for physicians and a key advocate for patients, patient care, and the public health, our AMA is concerned about the shortages of basic medical supplies such as sterile saline, medications for which the vehicle for intravenous administration is sterile saline, and any containers for sterile saline or injectable medications which are a component of our nation’s drug shortage problems. The AMA welcomes the application of critical infrastructure terminology and policies to the drug shortage challenges clinicians face each day.

RECOMMENDATION

The CSAPH recommends that Policy H-100.956 be amended by addition and deletion to read as follows:

National Drug Shortages

1. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply experience drug shortages, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.

2. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

3. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing...
capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

4. The Council on Science and Public Health shall continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

5. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.

6. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

7. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

8. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

9. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.

10. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and provide more detailed information regarding the causes and anticipated duration of drug shortages.

11. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.

12. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.

13. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

14. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients. (Modify Current HOD Policy)

Fiscal Note: Less than $500
REFERENCES


Box 1. Resources available to assist in mitigation of drug shortages.

1. ASHP Resource Center
2. ASHP list of current shortages
3. ASHP and University of Utah guidance on small-volume parenteral solutions shortages
4. ASHP and University of Utah guidance on injectable opioid shortages
5. FDA Drug Shortages Page (includes current shortages list, mobile app, and additional information)
6. US Department of Health and Human Services’ Office of the Assistant Secretary for Preparedness and Response [link]
7. ISMP newsletter on managing drug shortages
8. American Society for Parenteral and Enteral Nutrition guidance on shortages with parenteral nutrition components
9. NEJM article detailing Brigham and Women’s Hospital Oral Rehydration Protocol

Box 2. Recommendations resulting from the ASHP Drug Shortages Roundtable.

1. Manufacturers should provide the FDA with more information on the causes of the shortages and their expected durations.
2. Establish best practices for high-alert drugs.
3. FDA should require manufacturers to establish contingency plans and/or redundancies.
4. FDA should establish incentives to encourage manufacturers to produce drugs in shortage.
5. FDA should provide more information on the quality of outsourcing facilities’ compounding.
6. Reconsider the purchasing process of saline.
7. Manufacturers need to be more transparent.
8. Examine drug shortages as a national security initiative.
9. Request electronic health records (EHR) vendors to employ changes to their systems to ease the burden of making drug product changes.
10. FDA should establish a quality manufacturing initiative.
11. FTC should include in its review of drug company merger proposals the potential risk for drug shortages.
APPENDIX

Figure 1.

National Drug Shortages
New Shortages by Year
January 2001 to December 31, 2017

Note: Each column represents the number of new shortages identified during that year.
University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr

Figure 2.

National Drug Shortages – Active Shortages by Quarter

Note: Each column represents the number of active shortages at the end of each quarter.
University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr
Figure 3.

Active Shortages
Top 5 Drug Classes

Active Shortages December 31, 2017

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antimicrobials</td>
<td>25</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>13</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>19</td>
</tr>
<tr>
<td>CNS</td>
<td>25</td>
</tr>
<tr>
<td>E-Lytes, Nutrition</td>
<td>37</td>
</tr>
<tr>
<td>Fluids</td>
<td></td>
</tr>
</tbody>
</table>

University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr

Figure 4.

Reasons for Shortages as Determined by UUDIS During Investigation

2017

- Not Reported: 53%
- Manufacturing: 30%
- Supply/demand: 8%
- Natural Disaster: 2%
- Raw Material: 2%
- Discontinuation: 4%

University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr
Subject: Prescription Drug Donation
   (Resolution 207-I-17 and Resolution 525-A-17)

Presented by: Robert Gilchick, MD, MPH, Chair

Referred to: Reference Committee E
   (Douglas Martin, MD, Chair)

Resolution 207-I-17, “Redistribution of Unused Prescription Drugs to Pharmaceutical Donation
and Reuse Programs,” introduced by the Medical Student Section and referred by the House of
Delegates asked:

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

Resolution 525-A-17, “Providing for Prescription Drug Donation,” introduced by the Organized
Medical Staff Section and referred by the House of Delegates asked:

   That our American Medical Association advocate for new federal legislation that would allow:
1) nursing homes to recycle prescription drugs that are unused, sealed, and dated; 2) physician
offices and clinics to donate prescription drugs that are unused, sealed, and dated to patients in
need who are uninsured or underinsured; and, 3) cancer programs and clinics to accept and
recycle cancer-specific drugs to patients in need who are uninsured or underinsured.

Both of these resolutions reflect concerns about the intersection of rising drug costs, wastage and
expiration of unused pharmaceutical products prompting their disposal, and existing problems with
patient access and their ability to pay for needed therapies.

The Council previously examined the issue of pharmaceutical expiration (and beyond use) dates
and their clinical and fiscal consequences.1 Expiration and beyond use dates are tangentially related
to prescription drug donation and/or recycling because they are fundamental criteria used to
establish or reaffirm the integrity of returned products.

A fundamental goal expressed by both resolutions is minimizing the quantity of unused
prescription medications while decreasing healthcare costs. A prevailing issue is how unused
prescription medications that have been dispensed can be safely returned and reused. One way to
lessen prescription drug waste on the front end is for physicians and other prescribers to limit
quantities of prescription medications for acute therapy and/or during the initiation (trial phase) of
drug treatment for a chronic condition when the safety and efficacy of such treatment is being
evaluated. The other approach, which is the focus of this report, is to recycle and re-dispense
unused medications.
CURRENT AMA POLICY

The AMA has well developed policy on the recycling of nursing home drugs based on a Council report issued in 1997. At the time, it was estimated that nearly 7% of monthly medication costs were going to waste in this setting due to patient death, discontinuation of medication, a change in medication, patient transfer or hospitalization. Policy H-280.959, “Recycling of Nursing Home Drugs,” supports the return and reuse of medications to the dispensing pharmacy to reduce waste associated with unused medications in long-term care facilities (LTCFs) provided the following conditions are satisfied:

- The returned medications are not controlled substances.
- The medications are dispensed in tamper-evident packaging and returned with packaging intact (e.g., unit dose, unused injectable vials and ampules).
- In the professional judgment of the pharmacist, the medications meet all federal and state standards for product integrity.
- Policies and procedures are followed for the appropriate storage and handling of medications at the LTCF and for the transfer, receipt, and security of medications returned to the dispensing pharmacy.
- A system is in place to track re-stocking and reuse to allow medications to be recalled if required.

CURRENT STATUS OF PRESCRIPTION DRUG DONATION/REUSE PROGRAMS

Complicating the issue of recycling or medication reuse is guidance from the U.S. Food and Drug Administration (FDA) (CPG Sec. 460.300, “Return of Unused Prescription Drugs to Pharmacy Stock”) that states:

“A pharmacist should not return drugs products to his stock once they have been out of his possession. It could be a dangerous practice for pharmacists to accept and return to stock the unused portions of prescriptions that are returned by patrons, because he would no longer have any assurance of the strength, quality, purity or identity of the articles.”

Furthermore,

“The pharmacist or doctor dispensing a drug is legally responsible for all hazards of contamination or adulteration that may arise, should he mix returned portions of drugs to his shelf stocks. Some of our investigations in the past have shown that drugs returned by patrons and subsequently resold by the pharmacist were responsible for injuries.”

The language from the compliance guide is advisory in nature.

While Resolution 525-A-17 seeks federal legislation to support the recycling of “nursing home drugs,” both medical and pharmacy practice are regulated by the states. Our AMA supports state regulated medical and pharmacy practice. Increasingly state legislation, federal legislation, and regulations affecting activities of the FDA (e.g., risk evaluation and mitigation strategies) and certain policies implemented by payers, pharmaceutical benefit management companies, and pharmacy chains are restricting prescriber behavior, especially with respect to the use of opioid analgesics and other controlled substances. With respect to the specific issues raised in this report, states regulate such activities, therefore the federal approach advocated for in Resolution 525-A-17 is not further evaluated or recommended.
Resolution 207-I-17 seeks to draft and promote model legislation aimed at developing better funding for drug donation programs on the state level, as long as such programs follow the quality assurance guidelines described in Policy H-280.959. In October 2012, the National Association of Boards of Pharmacy (NABP) convened a task force on “Drug Return and Reuse Programs” to develop a position statement and revise its model act that addresses “the circumstances in both the community setting and in state-mandated-repository programs under which previously dispensed medications may be re-dispensed to patients.”

Return and Reuse of Prescription Drugs. NABP “endorses the return and reuse of medications that have been maintained in a closed system.” A closed system is defined as the “delivery to and/or return of prescription medication from a healthcare or other institutional facility, which is maintained in a controlled environment under a health care practitioner and not the patient.” This approach helps ensure the integrity of the medication. Prescription drugs should only be returned and reused when the drugs were removed from the pharmacy for delivery by pharmacy staff, a pharmacy contracted delivery service, or approved common carrier and the drugs were returned immediately, either because they were “not deliverable” or the patient refused to accept the delivery. Additionally, the returned product must remain packaged in the manufacturer’s original, sealed, and tamper-evident packaging, or the dispensing pharmacy’s original packaging. If an approved common carrier is used, product quality also must meet United States Pharmacopeia (USP) standards. Additional criteria that must be met for return and reuse include:

- All returned packaging must indicate that product integrity and stability has been maintained.
- All returned packaging must have been returned on the same day as the attempted delivery and must be evaluated to ensure it is not adulterated or could be considered misbranded.
- A state-licensed pharmacist must verify compliance with all of the above elements.

Prescription Drug Repository Programs. In contrast to the limited and unique circumstances described for a “return and reuse” program, a prescription drug repository program would be able to accept drugs that are not confined to a delivery service. Although NABP “does not endorse the reuse of medications that have left closed distribution systems,” for states that establish repositories, such programs should be registered and under the jurisdiction of the Board of Pharmacy and be subject to inspection. Strict criteria would apply to the policies, procedures and qualification of acceptable medications for reuse. Controlled substances are not accepted, and the medication must be judged to be unadulterated, unexpired, and in unopened unit dose or manufacturer’s tamper-resistant original packaging. Additionally, such drugs must have been originally dispensed by a pharmacist or practitioner acting within their scope of practice, and upon return be kept in a separate inventory and undergo monthly expiration date review with record keeping.

In recent years, several states have legalized and implemented charitable return and reuse programs involving drugs obtained from various donation sources. According to the 2018 Survey of Pharmacy Law, 42 states currently have authorized prescription drug repository programs. A few states that have not authorized repository programs allow return and reuse; with few exceptions, states that have authorized repositories also allow return and reuse. In some cases repositories are operational only for long term care facilities and/or correctional institutions, or charitable recipients, or the program only accepts products directly from wholesalers, distributors, or hospitals; in some cases medications are accepted from outpatients. In general, the provisions in enacted legislation are comparable to the requirements contained in the NABP model legislation. Differences may exist regarding which non-controlled drugs are accepted, criteria for eligible
A substantial majority of states have authorized drug repository and/or return and reuse programs for prescription medications that are unexpired and in their original container or tamper proof packaging. Repository programs must address concerns with allowing donation and reuse of medications that have left controlled environments such as a pharmacy or institutional facility. Such concerns may include storage conditions affecting product integrity and issues specific to accepting drugs back into the supply chain that have left licensed entities that are part of the normal supply chain with track and trace requirements (i.e., possible counterfeiting or other substandard drug sources). Nearly half of the authorized programs in existence do not appear to be operational. Model state legislation to establish “return and reuse” or drug repository programs is available from the NABP. Such programs have the potential to provide pharmaceutical care to patients who cannot afford their medications, reduce waste and environmental disposal, and reduce healthcare costs. Several states have demonstrated measurable success in implementing these types of programs.
RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 207-I-17 and Resolution 525-A-17 and the remainder of the report be filed:

Our AMA encourages:

1. States with laws establishing prescription drug repository and/or “return and reuse” programs to implement such laws and to consider integrating them with existing recycling or disposal programs. (New AMA Policy)

2. States that lack drug repository and/or “return and reuse” programs to enact such laws in consultation with their state board of pharmacy. (New AMA Policy).

3. State medical associations in states where there is a prescription drug repository or a “return and reuse” program for unused medication supplies to educate physicians in their state regarding the existence of such programs. (New AMA Policy).

Fiscal Note: less than $500
REFERENCES


Whereas, Synthetic cannabinoid receptor agonists, such as JWH-018 and HU-210, have recently been gaining popularity as psychoactive substances\(^1\); and

Whereas, These synthetic substances are full agonists at cannabinoid receptors, are more potent than delta-9-tetrahydrocannabinol (THC), and can cause severe illness and even death\(^2\); and

Whereas, Synthetic cannabinoid use can lead to physical and psychological dependence, with abrupt cessation of use after long-term use leading to withdrawal-like symptoms, suggesting these substances are addictive\(^3\); and

Whereas, Some persons elect to use them since they can be obtained legally in many parts of the United States and are not detected by most standard drug screens, including assays for THC; therefore be it

RESOLVED, That our American Medical Association recognize that synthetic cannabinoids such as JWH-018, JWH-210, and other compounds sold by "street" names such as "Spice" and "K2", are potent agonists in the mammalian endocannabinoid system and are dangerous when smoked or consumed (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that the Schedule I status of synthetic cannabinoids under the federal Controlled Substances Act should be retained since these compounds are "drugs with no currently accepted medical use and a high potential for abuse" (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that in any state or other jurisdiction in the U.S. considering changes in the legal status of cannabis, those changes should make explicitly clear that synthetic cannabinoids are unsafe and unfit for human consumption and their possession, use, sale and distribution by persons of all ages should remain illegal. (New HOD Policy)

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

Received: 04/17/18

---

\(^3\) Centers for Disease Control and Prevention (CDC). (2017) “Synthetic Cannabinoids: An Overview for Healthcare Providers.” Available at: https://www.cdc.gov/nceh/hsb/chemicals/sc/healthcare.html#one
RELEVANT AMA POLICY

Cannabis Legalization for Recreational Use H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for recreational use should not be legalized; (3) discourages cannabis use, especially by persons vulnerable to the drug’s effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (3) believes states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis use; and (6) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use.
CSAPH Rep. 05, I-17
Whereas, Almost 500,000 children in the United States suffer from epilepsy and approximately thirty percent of those children’s seizures are not adequately controlled by current anti-convulsant medications; and

Whereas, Childhood-onset, encephalopathic epilepsies, such as Dravet syndrome and Lennox Gastaut syndrome, are even more treatment resistant, with as many as 80-90% of children’s seizures resistant to available anti-convulsant medications; and

Whereas, There is an urgent need for new U.S. Food and Drug Administration (FDA)-approved treatment options for these childhood encephalopathies; and

Whereas, Cannabidiol has no effect on the receptors that produce euphoria with THC (tetrahydrocannabinol); and

Whereas, Recent controlled clinical trials with cannabidiol (CBD) suggest that CBD may be a promising treatment option for these encephalopathies; and

Whereas, In the absence of an FDA-approved CBD medication, desperate families are turning to these unapproved cannabis and CBD products in an effort to reduce their child’s seizures; and

Whereas, Many manufacturers of unapproved CBD products sold online make unsupported medical claims of safety and efficacy, including that their products will treat epilepsy and cancer, and in 2015, 2016, and 2017, the FDA sent Warming Letters to a number of these manufacturers, requiring them to cease making such claims; and

Whereas, CBD is classified in Schedule I or is defined as marijuana under virtually all of the states’ laws and, therefore, upon FDA approval and U.S. Drug Enforcement Administration rescheduling, each state must make changes to state law in order for pharmacies and prescribers to sell and dispense CBD containing medication; and

Whereas, The need to make such changes to state law to allow a CBD medication, once it is FDA approved, to be dispensed may result in a delay in access for children suffering from such encephalopathies; and

Whereas, If state laws are not corrected to allow medical dispensing, the only option for obtaining FDA-approved medication may require registration on special state patient registries, may require distribution through cannabis dispensaries, and may impose labeling requirements that are not consistent with FDA-approved labeling; therefore be it
RESOLVED, That our American Medical Association encourage state controlled substance authorities, boards of pharmacy, and legislative bodies to take the necessary steps including regulation and legislation to reschedule U.S. Food and Drug Administration (FDA)-approved cannabidiol products, or make any other necessary regulatory or legislative change, as expeditiously as possible so that they will be available to patients immediately after approval by the FDA and rescheduling by the U.S. Drug Enforcement Administration (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that an FDA-approved cannabidiol medication should be governed only by the federal and state regulatory provisions that apply to other prescription-only products, such as dispensing through pharmacies, rather than by these various state laws applicable to unapproved cannabis products. (New HOD Policy)

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

Received: 04/25/18
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-18)

Introduced by: Medical Student Section

Subject: Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians

Referred to: Reference Committee E
(Douglas W. Martin, MD, Chair)

Whereas, The rate of overdose deaths involving opioids in the United States increased two hundred percent between 2000 and 2014;¹ and

Whereas, Nineteen states experienced a statistically significant increase in opioid related deaths between 2014 and 2015;² and

Whereas, There is a scarcity of data regarding non-fatal overdoses that would be beneficial when implementing real-time, community-specific opioid overdose prevention programs;³ and

Whereas, One shared purpose for the introduction of overdose reporting policies in several states was to allow for real time monitoring of areas most at-risk, resulting in immediate response through preventative measures (such as Naloxone distribution) to those areas with rises in overdose rates;⁴,⁵,⁶,⁷ and

Whereas, Overdose monitoring enables a state’s Department of Health to better understand risk factors for death among those with similar exposures or evaluate the potential benefits of programs put in place to respond to the epidemic;⁵ and

Whereas, It is imperative that health departments and other relevant stakeholders are provided with accurate, timely, and actionable information on drug-related overdose;⁸ therefore be it

RESOLVED, That our American Medical Association support non-fatal and fatal opioid overdose reporting to the appropriate agencies. (New HOD Policy)

RELEVANT AMA POLICY

**Increasing Availability of Naloxone H-95.932**
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organization, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA urges the Food and Drug Administration to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).


**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.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16;
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-18)

Introduced by: Medical Student Section

Subject: Ending the Risk Evaluation and Mitigation Strategy (REMS) policy on Mifepristone (Mifeprex)

Referred to: Reference Committee E
(Douglas W. Martin, MD, Chair)

Whereas, The Food and Drug Administration (FDA) often regulates medications by associating them with a drug-specific Risk Evaluation and Mitigation Strategy (REMS), with the goal of ensuring a drug’s benefits outweigh its potential risks;¹ and

Whereas, The FDA REMS policy states that “Mifeprex© must be dispensed to patients only in certain healthcare settings, specifically clinics, medical offices, and hospitals” and prevents the distribution of mifepristone (Mifeprex©) through retail pharmacies;² and

Whereas, A woman is 14 times more likely to die from pregnancy-related complications than taking mifepristone for a medical abortion;³ and

Whereas, The estimated mortality rate of Mifeprex© is 0.00063% based on data from 3 million women in the United States who have used the medication for abortion;³ and

Whereas, The FDA’s REMS for Mifeprex© impedes the provision of Mifeprex©, even after over a decade of safe use, without offering any demonstrated or even reasonably likely advantage;¹,⁴ and

Whereas, American College of Obstetricians and Gynecologists and the New England Journal of Medicine, among other prominent organizations, have called for the removal of the Mifeprex REMS given the drug’s history of safe use;¹,⁴ therefore be it

RESOLVED, That our American Medical Association support efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY

The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS) H-100.961

Our AMA urges that:

(1) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) require sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; (c) clearly specify that sponsors must assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available; and (d) conduct a long-term assessment of the prescribing patterns of drugs with REMS requirements.

(2) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information.

(3) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed.

(4) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner.

(5) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) urge sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; and (c) recommend that sponsors assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available.

(6) The FDA, in concert with the pharmaceutical industry, evaluate the evidence for the overall effectiveness of REMS with ETASU in promoting the safe use of medications and appropriate prescribing behavior.

(7) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information.

(8) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed.

(9) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner.

(10) The FDA solicit input from the physician community before establishing any REMS programs that require prescriber training in order to ensure that such training is necessary and meaningful, requirements are streamlined and administrative burdens are reduced.

Citation: (CSAPH Rep. 8, A-10; Reaffirmed: Res. 917, I-10; Appended: CSAPH Rep. 3, I-12)

See also:

Physician Awareness and Education About Pharmaceutical and Biological Risk Evaluation and Mitigation D-100.971
Pregnancy Termination H-5.983
Policy on Abortion H-5.990
Abortion H-5.995
Medical Training and Termination of Pregnancy H-295.923
Freedom of Communication Between Physicians and Patients H-5.989
Whereas, It is estimated that 10–12% of sexual assault victims in emergency rooms are suspected to be drug facilitated sexual assault (commonly known as date rape) victims;¹ and

Whereas, In a national college survey, 5.3% of undergraduate women report having been given drugs without their knowledge or consent and 0.6% of all surveyed women have been sexually assaulted while under the influence of a drug given without their knowledge or consent;² and

Whereas, Of the 31 women in this national survey who reported drug-facilitated sexual assault, only three had a blood or urine sample taken to test for drugs;² and

Whereas, Established accurate methods exist for testing the biological presence of common date rape drugs;³,⁴,⁵ and

Whereas, Federal law provides penalties up to 20 years of imprisonment when rape involves giving a victim a drug without the victim’s knowledge, rendering a charge very serious;¹ therefore be it

RESOLVED, That our American Medical Association study the feasibility and implications of offering drug testing at point of care for date rape drugs, including rohypnol, ketamine, and gamma-hydroxybutyrate, in cases of suspected non-consensual, drug-facilitated sexual assault. (Directive to Take Action)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Sexual Assault Survivor Services H-80.998
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
Citation: Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17;

Sexual Assault Survivors H-80.999
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (A) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (B) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (C) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (D) be informed of these rights and the policies governing the sexual assault evidence kit; and (E) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

Informing the Public & Physicians about Health Risks of Sedative Hypnotics, Especially Rohypnol H-515.968
The AMA re-emphasizes to physicians and public health officials the fact that Rohypnol (a benzodiazepine), other benzodiazepines, and other sedatives and hypnotics carry the risk of misuse, morbidity and mortality. The AMA supports public education and public health initiatives regarding the dangers of the use of sedatives and hypnotics in sexual abuse and rape, especially when mixed with ethanol ingestion.
Citation: Sub. Res. 408, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

Addressing Sexual Assault on College Campuses H-515.956
Our AMA supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting.
Citation: Res. 402, A-16;
Whereas, Gene therapy is defined as “an experimental technique that uses genes to treat or prevent disease”;¹ and

Whereas, Gene therapies in both human clinical trials and murine models have been shown to be effective in promoting endogenous production of various proteins such as erythropoietin, insulin-like growth factor-1, and vascular endothelial growth factor;²,³,⁴,⁵,⁶ and

Whereas, While the therapeutic benefits of such technology is promising, many are also considering the potential for misuse of such technology, including “gene doping”; and

Whereas, In 2008, the World Anti-Doping Agency (WADA) defined gene doping as the “nontherapeutic use of cells, genes, genetic elements, or modulation of gene expression, having the capacity to enhance performance.”;⁷,⁸ and

Whereas, Although to date there have been no confirmed instances of gene doping, the potential societal and health related consequences of gene doping have prompted a prophylactic investigation into detection techniques and the denouncement of such activity by many of the major governing bodies in this arena, including the International Olympic Committee (IOC), WADA, and various International Sports Federations;⁹,¹⁰,¹¹ and

Whereas, While the major institutional bodies relevant to doping in sports have condemned the use of gene doping, public opinion may diverge, as recent evidence suggests that the general

population may be in greater support of gene doping without consideration for ethical and medical repercussions;\textsuperscript{12,13} and

Whereas, Though the major sequelae of gene doping are still uncertain, potential long term effects have manifested as cancers, heart failure, and stroke;\textsuperscript{6,14} and

Whereas, While there is speculation that the technology to adequately detect gene doping in athletes already exists, no standardized protocol has yet to be developed for the detection or regulation of any type of gene doping in athletes;\textsuperscript{14,15,16,17} and

Whereas, While our AMA has recognized and supported the potential therapeutic effects of genomic editing (AMA Policy H-480.945) and denounced the use of pharmacologic substances for non-therapeutic purposes (H-470.994, H-470.972, H-470.978), it has not yet established a position regarding the various non-therapeutic applications and genetic manipulation of such technology; therefore be it

RESOLVED, That our American Medical Association partner with relevant institutions to encourage the development of safety guidelines, regulations, and permissible uses of performance enhancing, non-therapeutic gene therapies. (Directive to Take Action)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Non-Therapeutic Use of Pharmacological Agents by Athletes H-470.994

Our AMA: (1) opposes the use of drugs for the purpose of enhancing athletic performance or sustaining athletic achievement. This action in no way should be construed as limiting a physician's proper use of drugs in indicated treatment of athletic injuries or clinical symptoms of individual athletes; and (2) endorses efforts by state level high school athletic associations to establish programs which include enforceable guidelines concerning weight and body fat changes on a precompetition basis for those sports in which weight management is a concern.

Citation: (Res. 89 part 2, A-72; Reaffirmed: CLRPD Rep. C, A-88; Modified by Res. 401, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Medical and Nonmedical Uses of Anabolic-Androgenic Steroids H-470.972

Our AMA (1) reaffirms its concern over the nonmedical use of drugs among athletes, its belief that drug use to enhance or sustain athletic performance is inappropriate, its commitment to cooperate with various other concerned organizations, and its support of appropriate education and rehabilitation programs; (2) actively encourages further research on short- and long-term health effects, and encourages reporting of suspected adverse effects to the FDA; and (3) supports continued efforts to work with sports organizations to increase understanding of health effects and to discourage use of steroids on this basis.


See also: Blood Doping H-470.978; Genome Editing and its Potential Clinical Use H-480.945


\textsuperscript{11}Salamin, O. et al. Erythropoietin as a performance-enhancing drug: Its mechanistic basis, detection, and potential adverse effects. Molecular and Cellular Endocrinology. 2017 Jan.;S0303-7207(17):30043-X


Whereas, Complete knowledge of a patient’s opioid medication history is necessary for physicians to provide the best care, allows for open, honest dialogue and shared decision making;

Whereas, Prescription monitoring programs can provide information to physicians that may not be available within their electronic health records system about patients’ current and past opioid use, tolerance, potential drug interactions, and other risk factors the patient may have; and

Whereas, Usage of prescription monitoring programs may prevent dangerous prescribing patterns and limit polypharmacy; and

Whereas, Incomplete or inaccurate information limits providers’ ability to utilize prescription monitoring programs; and

Whereas, Opioid treatment programs do not currently report prescribing and dispensing activity to state prescription monitoring programs; and

Whereas, Patients on opioid replacement therapy are at high risk for overdose and being prescribed interfering medications such as benzodiazepines or other opioids; and

Whereas, Opioid treatment information in the prescription monitoring programs, which is obtained from opioid treatment programs, will help prevent other physicians from prescribing opioid or benzodiazepine medications that could interfere with medication assisted treatment in cases that the patient does not disclose their treatment; therefore be it

RESOLVED, That our American Medical Association amend Policy D-95.980, “Opioid Treatment and Prescription Drug Monitoring Programs,” by deletion as follows:

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs. (Modify Current HOD Policy)
Fiscal Note: Minimal - less than $1,000.

Date Received: 04/26/18

RELEVANT AMA POLICY:

**Opioid Treatment and Prescription Drug Monitoring Programs D-95.980**

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

Citation: (BOT Rep. 11, A-10)

**Drug Abuse Related to Prescribing Practices H-95.990**

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
   A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
   B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.
   2. Our AMA: A. promotes physician training and competence on the proper use of controlled substances; B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients; C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and D. encourages physicians to query a state’s controlled substances databases for information on their patients on controlled substances.
   3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.
   4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.


See also: Prescription Drug Monitoring Program Confidentiality H-95.946; Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947; Universal Prescriber Access to Prescription Drug Monitoring Programs H-95.927; Support for Prescription Drug Monitoring Programs H-95.929
AMERICAN MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution: 508  
(A-18)

Introduced by:  Medical Student Section

Subject:  Reintroduction of Mitochondrial Donation in the United States

Referred to:  Reference Committee E  
(Douglas W. Martin, MD, Chair)

Whereas, Mitochondrial diseases are estimated to affect approximately 1 in 4300 adults;¹ and

Whereas, There are no existing cures for mitochondrial diseases and current therapy is aimed at symptom alleviation and haltering disease progression;² and

Whereas, The in vitro technique known as mitochondrial donation was introduced in 1995 as a means of decreasing the incidence of inherited mitochondrial diseases;²,³ and

Whereas, Mitochondrial donation is a technique that involves the replacement of a prospective mother’s oocyte cytoplasm, containing defective mitochondria, with healthy donor oocyte cytoplasm;⁴ and

Whereas, As of 2002, the FDA’s Biological Response Modifiers Advisory Committee (BRMAC) estimated that over two dozen births had occurred in the US using this technique;⁵ and

Whereas, While data on the wellbeing and long-term health of these individuals is not available, research on monkeys conceived via mitochondrial donation suggests that the technique produces viable, healthy offspring;⁶ and

Whereas, BRMAC recommends that “any future work in mitochondrial donation procedures must be cleared by the FDA under Investigational New Drug exemptions” on the grounds that these births represented the first cases of human germline genetic modification;⁵ and

Whereas, In 2016, the Institute of Medicine released a statement that claimed the techniques in question only represent a modification of the germline when used to produce female offspring, and it rejected a wholesale prohibition of this research, and advised that the technique be limited to male embryos for the time being, such that the modifications would not be carried on to subsequent generations;⁷ and

Whereas, In 2015, the UK’s Human Fertilisation and Embryology Authority determined that the benefits outweigh the risks associated with mitochondrial donation, and the technique was subsequently legalized, making it available to the thousands of couples who could potentially benefit from it;  

Whereas, The FDA is prohibited from accepting applications for clinical research using mitochondrial replacement therapy as stipulated under federal law; therefore be it

RESOLVED, That our American Medical Association support regulated research to determine the efficacy and safety of mitochondrial donation as a means of preventing the transmission of mitochondrial diseases. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY:

E-7.3.6 Research in Gene Therapy & Genetic Engineering

Gene therapy involves the replacement or modification of a genetic variant to restore or enhance cellular function or the improve response to nongenetic therapies. Genetic engineering involves the use of recombinant DNA techniques to introduce new characteristics or traits. In medicine, the goal of gene therapy and genetic engineering is to alleviate human suffering and disease. As with all therapies, this goal should be pursued only within the ethical traditions of the profession, which gives primacy to the welfare of the patient.

In general, genetic manipulation should be reserved for therapeutic purposes. Efforts to enhance desirable characteristics or to improve complex human traits are contrary to the ethical tradition of medicine. Because of the potential for abuse, genetic manipulation of nondisease traits or the eugenic development of offspring may never be justifiable.

Moreover, genetic manipulation can carry risks to both the individuals into whom modified genetic material is introduced and to future generations. Somatic cell gene therapy targets nongerm cells and thus does not carry risk to future generations. Germ-line therapy, in which a genetic modification is introduced into the genome of human gametes or their precursors, is intended to result in the expression of the modified gene in the recipient’s offspring and subsequent generations. Germ-line therapy thus may be associated with increased risk and the possibility of unpredictable and irreversible results that adversely affect the welfare of subsequent generations.

Thus in addition to fundamental ethical requirements for the appropriate conduct of research with human participants, research in gene therapy or genetic engineering must put in place additional safeguards to vigorously protect the safety and well-being of participants and future generations.

Physicians should not engage in research involving gene therapy or genetic engineering with human participants unless the following conditions are met:

(a) Experience with animal studies is sufficient to assure that the experimental intervention will be safe and effective and its results predictable.

(b) No other suitable, effective therapies are available.

(c) Gene therapy is restricted to somatic cell interventions, in light of the far-reaching implications of germ-line interventions.

(d) Evaluation of the effectiveness of the intervention includes determination of the natural history of the disease or condition under study and follow-up examination of the participants’ descendants.

(e) The research minimizes risks to participants, including those from any viral vectors used.

(f) Special attention is paid to the informed consent process to ensure that the prospective participant (or legally authorized representative) is fully informed about the distinctive risks of the research, including use of viral vectors to deliver the modified genetic material, possible implications for the participants descendants, and the need for follow-up assessments.

Physicians should be aware that gene therapy or genetic engineering interventions may require additional scientific and ethical review, and regulatory oversight, before they are introduced into clinical practice.

AMA Principles of Medical Ethics: I,V,VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016


Whereas, Tetrahydrocannabinol (THC) is the primary psychoactive substance found in marijuana products, while Cannabidiol (CBD) is a chemically distinct compound found in marijuana products with no known psychoactive effects;¹ and

Whereas, CBD is not addictive and has been shown to produce anxiolytic, antipsychotic, antidepressant, and neuroproductive effects;²,³,⁴ and

Whereas, In one study, patients ages 1-30 years old with treatment resistant epilepsy had a 36.5% reduction in monthly motor seizures over a 12-week treatment period with CBD;³,⁴ and

Whereas, CBD is effective in pain management with minimal side effects, particularly in cases of multiple sclerosis and intractable cancer pain, and has been approved as a pain medication in Canada for both conditions,⁴,⁵ as well as having documented positive impacts on many neural circuits linked to addiction and drug-seeking behaviors, making it a potentially effective treatment for substance abuse disorders without significant side effects,⁵,⁶ and

Whereas, In 2016 the U.S. Food and Drug Administration granted Orphan Drug status to GW Pharmaceuticals for Epidiolex® (cannabidiol) for the treatment of Tuberous Sclerosis Complex;⁵,⁷ and

---

Whereas, The DEA has established a new drug code for marijuana extracts that moves all extracts “containing one or more cannabinoids that has been derived from any plant of the genus Cannabis, other than the separated resin (whether crude or purified) obtained from the plant” to a Schedule 1 drug (including CBD) DEA Schedule I drugs are defined as those with no accepted medical benefits, a high potential for abuse, or those that are not considered safe for human consumption, and Schedule 1 substances cannot be prescribed and can only be administered under federally approved research programs;⁸,⁹,¹⁰ and

Whereas, Moving CBD to a Schedule 1 drug removes its availability to patients benefiting from these effects in states without medical marijuana and significantly slows medical research in CBD trials;¹¹ and

Whereas, The Justice Department has installed new research proposals for medical marijuana and has asked Congress to block statutory medical marijuana protections with new appropriations language, while pursuing criminal prosecution for individuals using marijuana;¹² and

Whereas, The non-psychoactive², non-addictive³ properties of CBD address the stated concerns of the Justice Department regarding psychoactive drug use and abuse potential;¹² therefore be it

RESOLVED, That our American Medical Association support the reclassification of Cannabidiol as a non-scheduled drug. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Cannabis Legalization for Medicinal Use D-95.969
Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state’s laws; and (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.
CSAPH Rep. 05, I-17

See also: Cannabis and Cannabinoid Research H-95.952

---

Whereas, Alcohol use is a recognized modifiable risk factor for several common types of cancer, including liver, esophageal, oropharyngeal, laryngeal, breast and colon\(^1\); and

Whereas, Between 2006 and 2010, the Centers for Disease Control and Prevention reported that 88,000 deaths\(^2\) were attributed to excessive alcohol use in the United States; and

Whereas, Although the greatest risk of cancer is associated with high levels of consumption even light alcohol consumption is associated with a higher risk of esophageal, oral cavity and pharyngeal, and breast cancers with relative risks of 1.26, 1.13, and 1.04 respectively\(^3\); and

Whereas, The World Cancer Research Fund/American Institute for Cancer Research estimates a 5% increase in premenopausal breast cancer and a 9% increase in postmenopausal breast cancer per 10 grams of ethanol consumed per day\(^4\); and

Whereas, Drinking of alcohol, without the development of alcoholism or alcohol dependence, is an underappreciated cause of cancer; and

Whereas, Many people engage in excessive drinking without recognition of the risk factors it poses to health, including increased risk of developing cancer; and

Whereas, The International Agency for Research on Cancer classified alcohol as a group 1 carcinogen\(^5\); therefore be it

RESOLVED, That our American Medical Association recognize alcohol use as a modifiable risk factor for cancer (New HOD Policy); and be it further

RESOLVED, That our AMA support research and educational efforts about the connection between alcohol use and several types of cancer (New HOD Policy); and be it further

RESOLVED, That our AMA encourage physicians to counsel patients on the risks of alcohol use and cancer. (New HOD Policy)

\(^2\) Centers for Disease Control and Prevention: Alcohol use and health. [http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm](http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm)
RELEVANT AMA POLICY

Alcohol Abuse and the War on Drugs H-30.972
Our AMA (1) supports documenting the strong correlation between alcohol abuse and other substance abuse; (2) reaffirms the concept that alcohol is an addictive drug and its abuse is one of the nation's leading drug problems; and (3) encourages state medical societies to work actively with drug task forces and study committees in their respective states to assure that their scope of study includes recognition of the strong correlation between alcohol abuse and other substance abuse and recommendations to decrease the immense number of health, safety, and social problems associated with alcohol abuse. Citation: (Sub. Res. 97, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

Alcohol Use Disorder and Unhealthy Alcohol Use Among Women H-30.943
The AMA recognizes the prevalence of unhealthy use of alcohol among women, as well as current barriers to diagnosis and treatment. The AMA urges physicians to be alert to the presence of alcohol-related problems among women and to screen all patients for alcohol use disorder and dependence. The AMA encourages physicians to educate women of all ages about their increased risk of damage to the nervous system, liver and heart disease from alcohol and about the effect of alcohol on the developing fetus. The AMA encourages adequate funding for research to explore the nature and extent of alcohol use disorder and unhealthy alcohol use among women, effective treatment modalities for women with alcohol use disorder and unhealthy alcohol use, and variations in alcohol use among ethnic and other subpopulations. The AMA encourages all medical education programs to provide greater coverage on alcohol as a significant source of morbidity and mortality in women. Citation: CSA Rep. 5, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: CSAPH Rep. 01, A-17;

Screening and Brief Interventions For Alcohol Problems H-30.942
Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine. Citation: (CSA Rep. 14, I-99; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11)
Whereas, According to the National Institute on Drug Abuse, every day more than 115 Americans die after overdosing on opioids and these are our patients; and

Whereas, Drug overdoses in the State of Oklahoma have increased by 91% in the last 15 years and continue to rise. We lose nearly 1,000 Oklahomans per year due to a drug overdose. In the last 3 years, more than 1,300 newborns tested positive for substance exposure and went into withdrawal the moment they were born; and

Whereas, Anecdotally, a common death scenario is when recovering opioid abuse patient takes their usual dose of opioids after a prolonged period of sobriety; and

Whereas, AMA Policy D-95.987, “Prevention of Opioid Overdose,” is to educate physicians and at-risk patients, it does not specifically address education needs of recovering opioid abuse patients after significant sobriety time; therefore be it

RESOLVED, That our AMA amend Policy D-95-987 by addition to read as follows:

Prevention of Opioid Overdose D-95.987

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

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

3. That our AMA implement an appropriate education program for recovering opioid abuse patients and their friends/families that opioid use after significant sobriety time can result in overdose and death. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Received: 05/01/18
RELEVANT AMA POLICY

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.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16
Whereas, Cannabis is a psychoactive drug with a well-defined addiction potential, and its possession and use are now legal in many states under various circumstances; and

Whereas, The active compound in cannabis is THC (tetrahydrocannabinol), which is a ligand that binds to CB1 and CB2 receptors in the central nervous system and elsewhere; and

Whereas, Completely synthetic ligands for the CB1 receptor have been identified and synthesized, and are used to produce euphoria and related psychoactive effects, and go by street names such as “Spice” and “K2”; and

Whereas, The drugs known as synthetic cannabinoids have no medical indications, but are used by inhalation or ingestion primarily for their psychoactive effects; and

Whereas, These drugs are not manufactured by any legitimate pharmaceutical company; and

Whereas, The illicit source of synthetic cannabinoids leads to the potential for contamination with other potentially injurious compounds, with or without the knowledge of the purchasers and users of these drugs; and

Whereas, In Illinois there have been over 100 persons who have been exposed to a contaminant (identified in some of the cases as brodifacoum, a poison that is a vitamin K antagonist) that has resulted in a severe bleeding diathesis leading to hospitalization, the need for critical care services, and a number of deaths; and

Whereas, While nearly all of these patients so far have been in the state of Illinois and have sought care from Illinois physicians, there is potential for this to occur in other places across the United States; therefore be it

RESOLVED, That our American Medical Association encourage all physicians to become aware of the adverse psychiatric and medical effects, including coagulopathy with severe bleeding, related to the use of synthetic cannabinoids, which may or may not be contaminated (New HOD Policy); and be it further

RESOLVED, That our AMA encourage physicians to educate their patients about synthetic cannabinoids and strongly advise them that the use of these drugs carries significant health risks that can produce psychiatric morbidity and hematological mortality. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Received: 05/02/18
Intended for: Illinois
Subject: Hand Sanitizer Effectiveness
Referred to: Reference Committee E
(Douglas W. Martin, MD, Chair)

Whereas, Under current regulations, manufacturers can make wide-ranging claims about their products' effectiveness in killing germs; and

Whereas, Chemicals used in hand sanitizers may affect the reproductive system or the production of hormones; and

Whereas, The National Institute of Occupational Safety and Health maintains that washing with soap and water is the most effective way to kill germs; and

Whereas, The U.S. Food and Drug Administration is undertaking a review of health care and consumer antiseptic rubs and wash products, and final rules on both health care and consumer antiseptic rubs were issued in 2017 determining that certain active ingredients used in antiseptic products are not generally recognized as safe and effective; therefore be it

RESOLVED, That our American Medical Association urge the U.S. Food and Drug Administration and the Centers for Disease Control and Prevention to continue to study the use of hand sanitizers in clinical settings, including the risks and benefits to patients and health care professionals. (Directive to Take Action)

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

Received: 05/02/18
Whereas, Virtual reality offers realistic sensory experience that humans can interpret similarly to real life exposure\(^1\); and

Whereas, Public consumption of virtual reality is increasing, with one million virtual reality headsets sold in 2017 and 13.7 million expected in 2018\(^2\); and

Whereas, Children from ages 6-18 experience virtual reality as more vivid and real than those over the age 18, describing it as salient, immersive and similar to reality\(^3\); and

Whereas, Gaming disorder, defined as impaired control over gaming and greater prioritization of gaming over other activities, may be included on the 11th Revision of the International Classification of Disease (ICD-11)\(^4\); and

Whereas, Internet gaming disorder alone is estimated at impacting on average 4.7 percent of the population with studies ranging from 0.7-15.6 percent\(^5\); and

Whereas, Virtual reality raises concerns for mental health risks such as depersonalization disorder\(^6\), ethical risks about the use of personal data and personal privacy\(^6,7\), and physical risks, including the risk of falls and injuries associated with spatial movement affected by altered sense of reality\(^8\); and

Whereas, Despite these risks, current research has elucidated potential benefits of virtual reality in treating certain disorders, including alcohol dependence, psychosis, and stroke rehabilitation\(^9,10,11\); and

Whereas, As it currently stands, limited research exists on the effects of virtual reality on physical, cognitive, and social development of children and adolescents\(^9,12\); and

Whereas, Our AMA rejects the excessive portrayal of violence in various entertainment media, including videos and computer games, while encouraging the depiction of its medical consequences (H-515.974); and

Whereas, Our AMA supports heightened awareness of the need for monitoring and restricting of video game and internet use, related but distinct from virtual reality, to limit negative health effects (H-60.915); therefore be it

RESOLVED, That our American Medical Association support further study on the impact of virtual reality on human health. (New HOD Policy)
RELEVANT AMA POLICY

Mass Media Violence and Film Ratings H-515.974
Redressing Shortcomings in the Current System: The AMA: (1) will speak out against the excessive portrayal of violence in the news and entertainment media, including newscasts, movies, videos, computer games, music and print outlets, and encourage the depiction of the medical, social and legal consequences of violence by the media; (2) advises physicians to counsel parents about the known effects of media violence on children’s behavior and encouraging them to reduce the amount of violent programming viewed by their children; (3) monitors changes in the current ratings system and working through state medical societies to inform physicians and their patients about these changes; and (4) supports all other appropriate measures to address and reduce television, cable television, and motion picture violence.
Citation: (BOT Rep. 18, A-94; Modified: Res. 417, I-95; Appended: Sub. Res. 419, A-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation A-13)

Emotional and Behavioral Effects of Video Game and Internet Overuse H-60.915
Our AMAsupports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of games purchased and played for children 17 years old and younger.
Citation: CSAPH Rep. 01, A-17;

8 La Motte, S. The very real health dangers of virtual reality, Dec 13, 2017. CNN.
Whereas, In one study, 84 percent of the patients surveyed reported that they were not aware that several medications contained ingredients derived from pork and/or beef; and

Whereas, Approximately 63 percent of patients wanted their physicians, and 35 percent of the patients wanted their non-physician health care providers (e.g., pharmacists, nurses, etc.), to inform them when using such medications[1]; and

Whereas, In the same study, approximately 70 percent of physicians were unaware that several medications contain ingredients that might be against their patients’ religion, and 70 percent thought that it was important to inform their patients if such drugs were prescribed[1]; and

Whereas, The animal origin of some drugs may not always be known to staff prescribing or administering these drugs[2]; and

Whereas, A pilot study suggests that both patients and physicians think that patients should be informed whenever medications that contain pork- and/or beef-derived products are prescribed[1]; and

Whereas, In a multicultural context, it is essential that prescribers have a minimal level of awareness of patients’ religious sensitiveness so that these can be considered when prescribing[3]; and

Whereas, In one study, patients with religious prohibitions against consumption of pork and/or beef products might stop their medications when prescribed those with pork- and beef-derived gelatin and/or stearic acid[4]; therefore be it

RESOLVED, That our American Medical Association support efforts to improve cultural awareness pertaining to the use of animal-derived medications when considering different prescription options (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the U.S. Food and Drug Administration to make available to the public an easily accessible database that identifies medications containing ingredients derived from animals. (Directive to Take Action)

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

Received: 05/02/18
Whereas, The idea to increase the use of trash incinerators to produce heat/steam to generate electricity originated during an energy crisis during the Nixon administration; and

Whereas, As part of a financial decision in the 1970s, the city of Detroit decided to create the largest municipal solid waste incinerator in the nation, but this was not without controversy and opposition; and

Whereas, It required about $440 million in bond sales to create the Detroit incinerator and it was hypothesized that the cost of waste collection services would be offset by revenue generated from the sale of steam and electricity; and

Whereas, Health experts and environmentalists in southeast Michigan and southwestern Ontario even at the time opposed constructing this facility since it would put millions of tons of pollutants into the air that would increase morbidity rates; and

Whereas, The incinerator became operational in 1986, and due to the increase in pollution, the State of Michigan’s Department of Environment Quality required expensive new pollution control when the facility applied for permit renewals in 1991; and

Whereas, Due to a lack of funds to install this equipment, the City of Detroit sold the facility to financial holding companies for $54 million and the company issued bonds for $157 million to finance the new equipment; and

Whereas, These bonds were still being paid by the city until 2009; and

Whereas, The firms also received pollution tax credits worth about $200 million for the upgrade; and

Whereas, $4.1 million dollars in Brownfield tax credits are given to the incinerator’s board of directors for operation; and

Whereas, The trash base for the city of Detroit has dwindled as the population of Detroit has dwindled and the facility began importing trash from neighboring areas to stay operational; and

Whereas, Oakland County was responsible for 66 percent of the waste, while Wayne County produced 19 percent, leading to injustice as individuals in Detroit bear the health effects of neighboring areas’ trash; and
Whereas, In 2007-2008, City of Detroit residents were being charged about $172 per ton of
trash, which is five to seven times the cost per ton offered to neighboring areas and 14 times the
cost per ton offered to private haulers; and

Whereas, The incinerator is currently operated by the Michigan Waste Energy firm, a subsidiary
of Covanta Energy, and due to environmental regulations, they are restricted to burning two of
the three furnaces at one time amounting to approximately 2,800 tons of trash daily or 800,000
tons of trash yearly; and

Whereas, It is not financially beneficial to run the facility because the city of Detroit pays more
per ton to dispose of solid waste in this manner than our surrounding communities or other large
cities spend in disposing of their solid waste using other methods; and

Whereas, Detroit pays $125 per ton to get rid of municipal solid waste via the incinerator as
compared to $25 per ton to dispose in local landfills; and

Whereas, Generated steam and electricity are sold to Michigan Consolidated Gas/Detroit
Edison for $40 million annually; and

Whereas, The facility is one of the state’s leading producers of pollution producing 25 tons of
hazardous air pollutants annually as well as 1800 tons of sulfur dioxide, nitrous oxide, mercury
and lead; and

Whereas: The incinerator creates around 25 tons of hazardous wastes every year and over
1800 tons of pollutants; and

Whereas, The ash of slag byproducts of the incinerator are toxic and disposed into landfills; and

Whereas, Michigan landfills abide by both federal and stringent state regulations regarding
liners and general standards to prevent environmental contamination; and

Whereas, An inconsistency exists where individuals in the State of Michigan are banned from
burning trash under the Public Act 102 of 2012 and open burning is regulated under the Natural
Resources and Environmental Protection Act (Act 451 of 1994), yet facilities such as the
incinerator are exempt from such acts; and

Whereas, There is concern for those employed by the facility, but recycling and composting
create four to ten times more jobs than landfills or incinerators; and

Whereas, Recycling and composting could be made widespread, the presence of the incinerator
and those that are financially invested and profit from the facility continue to prevent taking
steps away from depending on this facility; and

Whereas, Currently only 11 percent of the city of Detroit residents participate in recycling; and

Whereas, According to the Environmental Protection Agency (EPA), burning municipal solid
waste creates nitrogen oxides, sulfur dioxides, mercury and dioxins along with the primary
greenhouse gas, carbon dioxide even after using modern scrubbing equipment; and
Whereas, It is well known that asthma rates are higher in Detroit as compared to the average rate in the rest of the state, it is important to note that asthma hospitalization rates are approximately three times that of the Michigan average for children living around the incinerator; and

Whereas, Data from the EPA in 2009 cited that from 1990 to 2003 asthma hospitalization rates were 75 percent higher in Wayne County than in the rest of the State of Michigan; and

Whereas, Hospital and health care costs of individuals affected by the pollution from the facility add to the cost burden of the facility; and

Whereas, The Great Lakes Environmental Law Center obtained information using the Freedom of Information Act, citing the facility for violating the clean air act (21 violations since 2015 for strong odors and 19 violations for carbon monoxide, sulfur dioxide, and particulate matter emissions above allowable limits); and

Whereas, Pollutants from the facility are known to cause cardiac disease, premature death, and premature birth all of which are higher in Detroit along with causing irritation to mucous membranes including the eyes, ear, nose, and throat; and

Whereas, According to EPA statistics 7,280 residents live within one mile of the facility and these residents suffer from respiratory related health issues; and

Whereas, In 2007 approximately 14 percent of the nation’s solid waste was burned in 89 incinerators around the country they only produced 3/1000 of the nation’s electricity and currently there are between 80 to 90 facilities in the U.S. that are still operational; and

Whereas, In the State of Michigan there are two trash burning facilities, one in Detroit and the other in Kent county; and

Whereas, At the current rate of deposition, Michigan has an estimated 27 years of landfill space available, our state currently imports 22.7 percent of yearly waste deposition from other states and countries; and

Whereas, Current yearly estimates of 0.16 percent of landfill waste originate from incinerator by-products, if all the incinerator waste was directed away from the incinerators and instead toward landfills without recycling or composting, it would only amount to 1.8 percent of yearly landfill waste; and

Whereas, The approach to dealing with waste currently directed toward incinerators could include a combination of reducing waste production, recycling, composting, and landfill usage as well as stopping the practice of importing trash from other states and nations; therefore be it
RESOLVED, That our American Medical Association amend policy H-135.939 by addition to read as follows:

Green Initiatives and the Health Care Community H-135.939

Our AMA supports and shall prioritize: (1) responsible waste management and clean energy production policies that do not pose health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of ‘green’ initiatives and activities by organizations, businesses, homes, schools, and government and health care entities (Modify Current HOD Policy); and be it further

RESOLVED, That our American Medical Association request and actively advocate for national legislation that bans waste incinicators in our nation due to their adverse health effects, negative environmental impact, and lack of cost effectiveness. (Directive to Take Action)

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

Received: 05/02/18

See AMA Policies:
Pollution Control and Environmental Health H-135.996
Green Initiatives and the Health Care Community H-135.939
Conservation, Recycling and Other "Green" Initiatives G-630.100
Stewardship of the Environment H-135.973

Sources:
Whereas, In 2017, multiple hurricanes impacted islands in the Caribbean, resulting in direct and indirect damages through destruction of property and loss of municipal power; and

Whereas, Recovery in those impacted areas has been slow, with several still without power today; and

Whereas, There is a concentration of pharmaceutical manufacturing in the Caribbean, notably on the island of Puerto Rico, from which the United States receives a significant amount of intravenous fluids and other medications; and

Whereas, Hospitals and pharmacies in the United States have seen a shortage of these products, with many shortages expected to continue to worsen further before they improve; therefore be it

RESOLVED, That our American Medical Association study the impact of natural disasters on the pharmaceutical supply chain and downstream effects on patient care, as well as the adequacy of our governmental response to mitigating these recent natural disasters (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association amend policy H-100.956 by addition to read as follows:

National Drug Shortages H-100.956
1. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that experience drug shortages, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
2. Our AMA supports authorizing the Secretary of Health and Human Services to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
3. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and lifesustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
4. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

5. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The Centers for Medicare & Medicaid Services should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.

6. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

7. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

8. Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

9. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages. (Modify Current HOD Policy)

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

Received: 05/02/18
Reference Committee F

BOT Report(s)

01  Annual Report
04  AMA 2019 Dues
20  Anti-Harassment Policy
33  Plan for Continued Progress Toward Health Equity
34  AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies
35  Model Hospital Medical Staff Bylaws

Resolution(s)

601  Creation of LGBTQ Health Specialty Section Council
602  Health Fitness Partnerships
603  Eliminating Food Waste Through Recovery
604  AMA Delegation Entitlements
REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-A-18

Subject: Annual Report

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

The Consolidated Financial Statements for the years ended December 31, 2017 and 2016 and the Independent Auditor’s report have been included in a separate booklet, titled “2017 Annual Report.” This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.
# Financial Highlights

Years ended December 31

<table>
<thead>
<tr>
<th>(Dollars in millions)</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td>$347.6</td>
<td>$323.7</td>
</tr>
<tr>
<td>Cost of products sold and selling expense</td>
<td>28.2</td>
<td>30.1</td>
</tr>
<tr>
<td>General and administrative expenses</td>
<td>297.3</td>
<td>272.3</td>
</tr>
<tr>
<td>Operating results before income taxes</td>
<td>22.1</td>
<td>21.3</td>
</tr>
<tr>
<td>Operating results</td>
<td>13.8</td>
<td>13.6</td>
</tr>
<tr>
<td>Non-operating items</td>
<td>45.4</td>
<td>24.1</td>
</tr>
<tr>
<td>Changes in defined benefit postretirement plans, other than periodic expense, net of tax</td>
<td>11.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Change in unrestricted equity</td>
<td>70.6</td>
<td>38.1</td>
</tr>
<tr>
<td>Change in temporarily restricted equity</td>
<td>0.1</td>
<td>(0.1)</td>
</tr>
<tr>
<td>Change in association equity</td>
<td>$70.7</td>
<td>$38.0</td>
</tr>
</tbody>
</table>

Association equity at year-end  
Employees at year-end  

Association operating results  
(in millions)  

1993 | 1995 | 1997 | 1999 | 2001 | 2003 | 2005 | 2007 | 2009 | 2011 | 2013 | 2015 | 2017 
$\text{ \$(8.9)}$ | $\text{\$(6.7)}$ | $\text{\$(1.7)}$ | $\text{\$(5.4)}$ | $\text{\$2.7}$ | $\text{\$4.9}$ | $\text{\$11.7}$ | $\text{\$20.1}$ | $\text{\$28.1}$ | $\text{\$30.3}$ | $\text{\$24.4}$ | $\text{\$23.9}$ | $\text{\$24.7}$ | $\text{\$22.5}$ | $\text{\$20.3}$ | $\text{\$13.6}$ | $\text{\$13.8}$ 

* Pro forma operating results from 2013 exclude $33 million in nonrecurring charges relating to the AMA’s headquarters relocation. The reported net operating loss, after including those charges, is $15.1 million.
Continuous improvement is perhaps the concept most responsible for pushing medical knowledge and professionalism forward. This year we write from the vantage point of an organization that has fully embraced this notion and is now seeing powerful results.

As demonstrated by a sweeping range of accomplishments delivered in 2017—from helping block multibillion dollar health insurance company mega-mergers in court to re-launching our web-based graduate competency training curriculum with its almost 20 percent increase in participation—the American Medical Association is having a measurable positive impact on the lives of patients and physicians.

Standing as an innovative and proactive force, today we are an organization driven like no other by evidenced-based research, strategic analysis and insight, and our unmatched commitment to understanding and amplifying the physician voice in arenas that matter most: advocacy, health policy, technology, life-long learning, governance, medical ethics, public health and clinical care.

As you view the AMA’s achievements from 2017, we are confident you will find the scale and relevance of our long-term investment in the nation’s health inspiring. In 2017, for example, we saw collaboration soar as the AMA, working with such notable allies as the American Heart Association, the Mayo Clinic and Stanford University, to name but a few, was instrumental in launching successful initiatives such as Target: BP™ and the first-ever American Conference on Physician Health.

We developed a proof-based recruitment campaign, underscoring the power and importance of AMA membership in moving medicine forward. We saw our innovation ecosystem continue to expand and propel major efforts like the Integrated Health Model Initiative™, with its focus on interoperability and more effective patient care, into the marketplace with tremendous promise and a blue-chip roster of participants on board. And we continued fine tuning our strategy to articulate more fully the AMA’s essential arcs of expertise: tools for the field, professional development and improved care for chronic disease.

With our strong performance in 2017 including positive financial operating results for the 17th time in the last 18 years and an increase in membership for the seventh straight year, the AMA’s sights are set on making even greater strides on the road ahead. In this report you will learn how our focus on results, innovation and collaboration have kept us on course for success.

We are privileged to be guided by a powerful mission to promote the art and science of medicine and the betterment of public health. In 2017 we protected access to coverage for millions of patients—going forward the AMA will continue developing significant ways to make health care delivery efficient, sustainable and fair, and we will continue working relentlessly to make patients’ and physicians’ lives better.
RESULTS THAT MATTER: WHERE WE MADE OUR MARK

Putting patients before politics

In 2017 the AMA empowered physicians and patients to contact Congress and to work with us to help preserve coverage for the 20 million Americans who gained coverage through the Affordable Care Act. We launched the website patientsbeforepolitics.org to cut through the noise surrounding this all-important debate on access to health insurance. Generating more than 7 million actions—including calls, emails and social interactions—this grassroots campaign resonated loudly and helped shape the health care debate on Capitol Hill.

Battling an epidemic

The AMA Opioid Task Force made strong inroads in helping the nation’s physicians battle one of the deadliest epidemics of our time. We can now report that, in addition to the AMA developing resources and advocating for practical policy changes, we saw meaningful progress: fewer opioids being prescribed, prescription drug monitoring program use increasing, and more physicians certified to provide office-based treatment for opioid disorder.

HEALTH REFORM DEBATE: DOMINANT SHARE OF VOICE IN THE MEDIA AMONG TOP 10 ADVOCACY PEERS

Based on the AMA’s “Health Reform Share of Voice Analysis” (Jan. 1–Sept. 30, 2017)
Having physicians’ backs

The AMA was instrumental in helping stop two separate health insurance company mega-mergers. The courts listened when organized medicine advocated for competition—not consolidation—in health insurance markets. Blocking the proposed Anthem-Cigna merger alone saved physicians at least $500 million in payments annually.

But the AMA’s effectiveness in protecting physicians’ interests didn’t end there. Our legal teams and policy experts worked together to achieve important victories defending physicians’ right to free speech, and medical staff representation and independence. They also delivered more than 130 state legislative and regulatory wins on issues ranging from unfair health insurer practices to the promotion of meaningful medical liability reform.

Making an impact

The JAMA Network™ continues to increase the amount of content produced, formats distributed, audience engagement, and the impact our content has on research and practice. In 2017 JAMA Oncology registered a debut impact factor of 16.6—the highest ever debut for a journal in clinical medicine—reflecting that journal’s immediate impact and impressive engagement. JAMA Cardiology, our other new specialty journal, will receive its debut impact factor in 2018.

JAMA Network downloads ▶ 70 million+
Times JAMA content viewed ▶ 31 million+
Podcasts downloaded and listened to ▶ 2 million+
JAMA’s impact factor* ▶ 44.4
JAMA Oncology debut impact factor* ▶ 16.6

* The impact factor, which is a publishing industry standard, is a measure of the frequency with which the average article in a journal has been cited in a particular year.

Expanding our reach

2017 earned media metrics

98,823 Total placements across all mediums in national, local, trade and new media outlets
$60 billion+ Estimated publicity value

Estimating traditional and online media impressions across print publications, radio, television, news services, news websites and blogs

Establishing health systems science

Having helped health systems science gain recognition as the third pillar of medical education, alongside basic and clinical science, the AMA is now seeing future physicians acquire the non-clinical background needed to succeed in medicine today. Underscoring this movement, Health Systems Science, first edition, developed by the AMA and the Accelerating Change in Medical Education Consortium, has already been adopted by 12 medical schools in the United States and sold thousands of copies around the world.

Helping physicians optimize payments

By surveying 1,000 practicing physicians involved in practice decisions related to the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program, The AMA revealed that, under the new rules of the Medicare and CHIP Reauthorization Act of 2015, 90 percent of physicians didn’t know what steps to take next. Based on the valuable insights our research yielded, the AMA developed educational and training resources to help physicians and their practices carve successful paths forward (if participating in the CMS Merit-based Incentive Payment System), and launched a comprehensive marketing and communications campaign to create awareness among physicians about this new payment program.
INNOVATION WITH PURPOSE: ADDRESSING UNMET NEEDS

Transforming health care

To unleash a new era of better and more effective patient care, the AMA in 2017 launched the ambitious Integrated Health Model Initiative™ (IHMI), a collaborative effort across a broad expanse of health care and technology stakeholders.

While addressing critical chronic diseases, IHMI will enable care models and technical solutions to be built on truly meaningful data elements, such as patient function, state and goals—elements that will allow health care efforts to focus on outcomes and achieving patient wellness while facilitating unparalleled semantic interoperability. Released to the public in late 2017, IHMI closed the year with more than 1,000 participants and 17 collaborating organizations onboard and eagerly looking to make a difference.

5.9 HRS
AMOUNT OF TIME PRIMARY CARE PHYSICIANS SPEND EACH WORKDAY ON DATA ENTRY AND OTHER EHR-RELATED TASKS
As revealed in a study co-authored by AMA senior staff and published in the Annals of Family Medicine
Putting our expertise and knowledge to work

In 2017 the AMA continued growing our innovation ecosystem in fertile new directions, and in ways that are radically expanding our understanding of the health care landscape’s deep and complex interconnections.

Extending to include innovative forces like Health2047, our flagship Silicon Valley-based integrated innovation studio, and MATTER, a Chicago-based health technology incubator and home to more than 200 digital start-ups—the AMA ecosystem is providing us with spectacular insights and opportunities to improve health care.

One example of our ecosystem at work is Health2047’s successful launch of Akiri, Inc.™ (formerly Health2047 Switchco, Inc.), the new company working to bring the first network-as-a-service platform to the health care industry. Known as Akiri Switch™, this platform will enable health information to move seamlessly and securely throughout the U.S. health care system.

Bringing the physician voice to technology

Developed to match companies and developers with physician entrepreneurs, the AMA Physician Innovation Network officially launched in late 2017. In just three months some 2,070 users (companies and physicians) joined the network and more than 1,000 connection requests were generated. An excited digital health community offered clear signals that it’s hungry for physician-driven innovations, publishing articles with titles like “Health IT Infrastructure Improves with AMA Collaboration Platform” (HIT Infrastructure) and “AMA’s New Online Platform Looks to Bring Together Docs, Health Tech Companies” (Healthcare Informatics).

Placing new ideas in the spotlight

The AMA continued raising its profile with the most inspiring change-makers both inside and outside of health and medicine. The AMA was a global sponsor of TEDMED 2017, where we unveiled “AMA Doc Talk,” a new podcast series that illuminates the very real challenge of helping physicians handle difficult conversations with patients.

Leading the adoption of digital medicine

In establishing the Digital Medicine Payment Advisory Group, the AMA again led the way in pushing for actionable, real-world solutions to help facilitate improved digital medicine adoption. This advisory group—composed of 14 recognized experts with years of hands-on experience integrating digital medicine services into clinical practice—is currently working to identify effective payment and coverage strategies with special emphasis placed on coding, coverage and payment for remote patient monitoring services.
POWERED BY COLLABORATION: TOGETHER WE ACCOMPLISH MORE

Ensuring safe, effective health technologies

Xcertia, the joint mobile health app collaborative pioneered by the AMA, the American Heart Association, DHX Group, and the Healthcare Information and Management Systems Society (or HIMSS), gained significant notice in 2017. Highlighted in The Wall Street Journal, Xcertia, with its 32 members—including IBM Watson, Accenture and the Mayo Clinic—is quickly progressing toward its goal of setting standards that foster safe, effective mobile health technologies.

TARGET: BP™

Moving millions toward blood pressure control

In collaboration with the American Heart Association (AHA) and the Ad Council, the AMA launched an evocative patient-facing high blood pressure campaign, which has already attracted more than 400,000 visitors to loweryourhbp.org and over $4.7 million in donated national media placements.

Also, following the release of a new hypertension guideline in late 2017, the AMA and AHA provided solid guidance to physicians and care teams, generating more than 500,000 acts of engagement via a variety of platforms, including the AMA/AHA jointly produced Target: BP™ web platform, which contains vetted resources and information designed to make tighter blood pressure control achievable.

THE AMA IS PARTNERING WITH 11 RESIDENCY PROGRAMS LOOKING TO BRING ITS BURNOUT ASSESSMENT TO THEIR INSTITUTIONS

Providing new information to help reduce burnout in this critical but previously untapped area
Putting future physicians ahead of the curve

In 2017 medical education leaders gathered for our AMA ChangeMedEd™ conference, which included presentations on the emergence of health systems science, innovative uses of technology and a range of other game-changing ideas.

To prepare tomorrow’s physicians to thrive, the AMA Accelerating Change in Medical Education Consortium implemented multiple innovations, including an EHR learning platform that is now in use at five schools. Consortium leaders were also very active in 2017, making 45 presentations at 28 national conferences, and writing and publishing 16 papers in peer-reviewed scientific literature on various aspects of the group’s groundbreaking work.

Helping physicians protect and serve patients

Working with Accenture, the AMA continued to help physicians enhance security for their patients by conducting a cybersecurity survey of 1,300 U.S. physicians. The survey revealed that four in five physicians have experienced a cyberattack in their practices. In response, the AMA is now providing information to assist physicians in improving cybersecurity measures.

LexisNexis® Risk Solutions and AMA Business Solutions, a subsidiary of the AMA, tackled the complex challenge of inaccurate and outdated provider directories. Our collaboration produced VerifyHCP™, a one-stop online interface that lets physicians and practice managers verify and update their data with vastly improved efficiency. Since launch, VerifyHCP has almost 200 provider plan participants and manages nearly 200,000 unique clinician profiles.

Increasing prediabetes awareness

The AMA and the American Diabetes Association extended our ongoing collaboration to also include tech heavyweight Samsung. Together we created a first-of-its-kind mobile public awareness experience for U.S. adults. The initial five-week campaign far exceeded expectations by yielding 555,000 completed prediabetes risk assessments.

In addition, the AMA guided more than 40 health care organizations in developing prevention strategies for type 2 diabetes, including providing project support for those health systems seeking to establish their own CDC-recognized National Diabetes Prevention Program.

Making physician health a priority

In October 2017 the AMA, together with Stanford University School of Medicine and the Mayo Clinic, launched the first-ever American Conference on Physician Health to rave reviews. Held in San Francisco, this inaugural event brought together more than 400 physicians, academics, researchers and thought leaders from around the country to share ideas and seek solutions to improve physician wellness.

In 2017 we held two Joy in Medicine™ conferences. These multi-stakeholder conferences brought together nearly 100 participants to discuss issues relevant to physician burnout, including interventions and ideas for change.

Prevent Diabetes STAT

American Conference on Physician Health

ACPH 2017

In 2017 medical education leaders gathered for our AMA ChangeMedEd™ conference, which included presentations on the emergence of health systems science, innovative uses of technology and a range of other game-changing ideas.

To prepare tomorrow’s physicians to thrive, the AMA Accelerating Change in Medical Education Consortium implemented multiple innovations, including an EHR learning platform that is now in use at five schools. Consortium leaders were also very active in 2017, making 45 presentations at 28 national conferences, and writing and publishing 16 papers in peer-reviewed scientific literature on various aspects of the group’s groundbreaking work.

Helping physicians protect and serve patients

Working with Accenture, the AMA continued to help physicians enhance security for their patients by conducting a cybersecurity survey of 1,300 U.S. physicians. The survey revealed that four in five physicians have experienced a cyberattack in their practices. In response, the AMA is now providing information to assist physicians in improving cybersecurity measures.

LexisNexis® Risk Solutions and AMA Business Solutions, a subsidiary of the AMA, tackled the complex challenge of inaccurate and outdated provider directories. Our collaboration produced VerifyHCP™, a one-stop online interface that lets physicians and practice managers verify and update their data with vastly improved efficiency. Since launch, VerifyHCP has almost 200 provider plan participants and manages nearly 200,000 unique clinician profiles.

Increasing prediabetes awareness

The AMA and the American Diabetes Association extended our ongoing collaboration to also include tech heavyweight Samsung. Together we created a first-of-its-kind mobile public awareness experience for U.S. adults. The initial five-week campaign far exceeded expectations by yielding 555,000 completed prediabetes risk assessments.

In addition, the AMA guided more than 40 health care organizations in developing prevention strategies for type 2 diabetes, including providing project support for those health systems seeking to establish their own CDC-recognized National Diabetes Prevention Program.

Making physician health a priority

In October 2017 the AMA, together with Stanford University School of Medicine and the Mayo Clinic, launched the first-ever American Conference on Physician Health to rave reviews. Held in San Francisco, this inaugural event brought together more than 400 physicians, academics, researchers and thought leaders from around the country to share ideas and seek solutions to improve physician wellness.

In 2017 we held two Joy in Medicine™ conferences. These multi-stakeholder conferences brought together nearly 100 participants to discuss issues relevant to physician burnout, including interventions and ideas for change.

Prevent Diabetes STAT

American Conference on Physician Health

ACPH 2017

In 2017 medical education leaders gathered for our AMA ChangeMedEd™ conference, which included presentations on the emergence of health systems science, innovative uses of technology and a range of other game-changing ideas.

To prepare tomorrow’s physicians to thrive, the AMA Accelerating Change in Medical Education Consortium implemented multiple innovations, including an EHR learning platform that is now in use at five schools. Consortium leaders were also very active in 2017, making 45 presentations at 28 national conferences, and writing and publishing 16 papers in peer-reviewed scientific literature on various aspects of the group’s groundbreaking work.

Helping physicians protect and serve patients

Working with Accenture, the AMA continued to help physicians enhance security for their patients by conducting a cybersecurity survey of 1,300 U.S. physicians. The survey revealed that four in five physicians have experienced a cyberattack in their practices. In response, the AMA is now providing information to assist physicians in improving cybersecurity measures.

LexisNexis® Risk Solutions and AMA Business Solutions, a subsidiary of the AMA, tackled the complex challenge of inaccurate and outdated provider directories. Our collaboration produced VerifyHCP™, a one-stop online interface that lets physicians and practice managers verify and update their data with vastly improved efficiency. Since launch, VerifyHCP has almost 200 provider plan participants and manages nearly 200,000 unique clinician profiles.

Increasing prediabetes awareness

The AMA and the American Diabetes Association extended our ongoing collaboration to also include tech heavyweight Samsung. Together we created a first-of-its-kind mobile public awareness experience for U.S. adults. The initial five-week campaign far exceeded expectations by yielding 555,000 completed prediabetes risk assessments.

In addition, the AMA guided more than 40 health care organizations in developing prevention strategies for type 2 diabetes, including providing project support for those health systems seeking to establish their own CDC-recognized National Diabetes Prevention Program.
2017 MANAGEMENT’S DISCUSSION AND ANALYSIS
Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management’s views on the AMA’s financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Results from operations

(in millions)

Improving the health of the nation is at the core of the AMA’s work to enhance the delivery of care and enable physicians and health teams to partner with patients to achieve better health for all. The focus of our efforts is on creating thriving physician practices, creating the medical school of the future and improving health outcomes.

In 2017, AMA continued to maintain its focus on Practice Sustainability and Professional Satisfaction, working with physicians to advance initiatives that will help them navigate and succeed in a continually evolving environment; Accelerating Change in Medical Education by collaborating with medical schools to create a system that trains physicians to meet the needs of today’s patients and to anticipate future changes; and Improving Health Outcomes by enabling physicians and health teams to partner with patients, communities and public and private-sector organizations to enhance the delivery of care and achieve better health for all.

In a challenging environment, the AMA continued to deliver strong advocacy results in 2017. The AMA was successful in efforts to protect access to coverage for millions of Americans, defend key patient protections, and preserve the safety net for our nation’s most vulnerable patients. The AMA was instrumental in blocking two mega-health insurance mergers that would have had negative effects on patients and physicians. Physicians stood to lose an estimated $500 million in annual payments from just the Anthem-Cigna merger alone. The AMA sought and achieved numerous improvements to the Medicare Quality Payment Program (QPP) regulations to help physicians succeed with the transition. Last year, the AMA launched a campaign to address the prior authorization burden physicians and their staff experience and continued to achieve positive outcomes on other administrative and regulatory burdens, including Medicare audits and virtual credit card payment mandates. Finally, the AMA continued efforts to end the opioid epidemic that is having a devastating impact across the United States, making inroads on reducing opioid prescribing, increasing physician education, and improving the availability of naloxone.

AMA’s innovation enterprise, Health2047, has made substantial progress on key projects, including the spinout of a new company, Health2047 SwitchCo, Inc. (SwitchCo), which will build and deploy trusted infrastructure for private data transport, optimized for healthcare data. The studio will continue to enhance AMA’s ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice.

2017 saw many other important new initiatives, such as the successful launch of the Integrated Health Model Initiative and Membership Moves Medicine and brand campaign, laying the groundwork for the launch of JAMA Network Open; expansion of the education center, continued physician engagement efforts and expansion of digital marketing; as well as enhancing infrastructure support for new initiatives and the strategic focus areas. In 2017, AMA is reporting $13.8 million in net operating income, reflecting continued growth in revenue offset by additional investment in the focus areas, core activities and new initiatives.

The AMA is committed to its responsibility to ensure that the organization focuses its finite resources on its core activities and strategic focus areas while improving the quality and breadth of products and services for physicians and medical students. Our physicians’ and medical students’ presence and voice are central to the overall success of our AMA.
Our AMA’s strategy requires continued focus and integration within and across all components of the AMA Equation: the House of Delegates; membership; physician practice tools; advocacy; and research and education.

The following pages discuss the 2017 consolidated results from operations, financial position and cash flows, as compared to 2016. Additional detailed discussion of operating unit results is included in the section titled “Group Operating Results.”

Consolidated financial results

The chart below provides pro forma results from operations and excludes the $33 million in nonrecurring charges related to the headquarters relocation in 2013.

### Results from operations

(in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Pro forma 2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td>$17.9</td>
<td>$22.5</td>
<td>$20.3</td>
<td>$13.6</td>
<td>$13.8</td>
</tr>
</tbody>
</table>

### Revenues

In 2017, total revenues improved by $23.9 million over the prior year, due to continued growth in AMA’s royalties and journal site licensing. Advertising revenue and coding book sales declined again during 2017, reflecting a continued transition from print journals and books.

The number of AMA dues-paying memberships increased in 2017 by 1.8 percent, achieving seven years of consecutive growth in members. Similar to the prior year, increases occurred in lower dues-paying categories such as group memberships, sponsored memberships and half-year dues, resulting in a small dues revenue decline of 3 percent.

Consolidated investment income increased slightly in 2017, reflecting larger investable balances. Interest rates continued at historic low levels.

### Cost of products sold and selling expenses

All variable expenses related to the production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2017, cost of products sold and selling expenses decreased $1.9 million. A substantial portion of the decrease is from reduced production costs related to the lower volume of book sales and fewer journal advertising pages.

### Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased $25.8 million to $319.4 million in 2017, with Books and Digital Content accounting for most of the change. Revenue improvements from royalties, offset by the declining book sales discussed above, were the key factors.

### General and administrative expenses

(in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Pro forma 2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>General and administrative expenses</td>
<td>$222.4</td>
<td>$223.3</td>
<td>$248.3</td>
<td>$272.3</td>
<td>$297.3</td>
</tr>
</tbody>
</table>

General and administrative expenses rose $25 million in 2017, or just over 9 percent.

Compensation and benefits increased $9 million, with higher compensation and employee health care expense offset by lower pension and retiree health costs. Compensation, including temporary help, was $7.3 million higher in 2017, a 4.5 percent increase. Health2047 accounted for $0.8 million of that increase in its continued expansion of operations. Increased incentive compensation accounted for another $1.2 million as the salary base increased and key performance
indicators were achieved in 2017. Excluding both the higher incentive and Health2047 costs, AMA salaries rose 4 percent in 2017, approximately half for merit increases and the remaining half for additions to support key initiatives.

Occupancy costs increased $1 million in 2017, reflecting the absence of a large property tax refund in 2016.

Technology costs increased $1.8 million in 2017, largely related to third party hosting and implementation of outsourced solutions for platforms such as the scientific journals, the education center and the new AMA website, as well as software amortization of new solutions.

Outside professional services were largely unchanged in 2017.

Marketing and promotion expenses rose $8.7 million, largely related to four campaigns, the brand and Membership Moves Medicine campaign; the healthcare reform campaign, the AMA-American Heart Association awareness campaign and the new hypertension guidelines campaign.

A $3.5 million increase in other operating expenses reflects a $1.8 million increase in grants and contributions, including a grant to assist in the development of a teaching electronic medical record (tEMR) and grants to areas devastated by hurricanes. Costs associated with a new venture to improve physician directories and a write-off of developed software were the other large factors in the overall increase.

Operating results before income taxes
The AMA achieved a $22.1 million pre-tax operating income in 2017. This compares to $21.3 million in 2016. A 7.4 percent increase in revenue was almost entirely offset by the general and administrative expense increases described above.

Income taxes
Taxes increased $0.6 million in 2017 as a result of a $1.1 million tax provision in Health2047, largely related to the spinout of SwitchCo, offset by a small tax benefit related to the change in federal corporate tax laws.

Net operating results
Operating income totaled $13.8 million in 2017, up slightly from the prior year, with improvements from increased revenue largely offset by higher expenses.

Non-operating items
The AMA reported a $45.3 million gain in the fair value of its portfolio during 2017 after a $24.1 million gain in 2016. AMA also reported $0.1 million in other non-operating revenue in 2017.

Revenue in excess of expenses
Revenues were $59.2 million greater than expenses in 2017, a combination of the $13.8 million operating income plus $45.4 million in non-operating gains. Revenues exceeded expenses by $37.7 million in 2016.

Change in association equity
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity. In 2017, the net credit to equity related to defined benefit postretirement plans totaled $11.4 million. Portfolio returns in the pension plan were better than the actuarial expectation, and claims experience in the retiree health plan were lower than the actuarial expectation, both resulting in actuarial gains. Recognition of actuarial losses and prior service credits in the postretirement health care plan added to the gains. The gains were partially offset by actuarial losses in both the pension plan and the postretirement health care plan resulting from year-end lower interest rates that increase the present value of plan liabilities. Deferred taxes on the credit reduced the overall gain.

In 2016, the net credit to equity related to defined benefit postretirement plans totaled $0.4 million. Actuarial losses in both the pension plan and the postretirement health care plan resulted from year-end lower interest rates that increase the present value of plan liabilities as well as participant changes. Portfolio returns in the pension plan were less than the actuarial expectation, and claims experience in the retiree health plan were higher than the actuarial expectation, both resulting in additional charges. Recognition of actuarial losses and prior service credits in the postretirement health care plan more than offset the losses. Deferred taxes on the credit slightly increased the gain.

The AMA reported a $70.6 million increase in unrestricted association equity in 2017. This reflects the amount by which revenues were greater than expenses, plus the credits to equity for changes in defined benefit postretirement plans discussed above. After adding a $0.1 million increase in temporarily restricted equity in 2017, total equity increased $70.7 million.

In 2016, total equity increased by $38 million, with $37.7 million of revenues in excess of expenses and $0.4 million in credits to equity for changes in defined benefit postretirement plans slightly reduced by a $0.1 million decrease in temporarily restricted equity.
Financial position and cash flows

The AMA’s assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, computer hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities and deferred revenue.

Assets
(in millions)

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and investments</td>
<td>$756.3</td>
<td>$848.7</td>
</tr>
<tr>
<td>Fiduciary funds</td>
<td>$88.3</td>
<td>$72.2</td>
</tr>
<tr>
<td>Operating assets</td>
<td>$54.6</td>
<td>$20.1</td>
</tr>
<tr>
<td>Property and equipment</td>
<td>$21.2</td>
<td>$701.4</td>
</tr>
<tr>
<td>Other assets</td>
<td>$626.3</td>
<td></td>
</tr>
</tbody>
</table>

The AMA’s total assets increased $92.4 million in 2017. This includes a $75.1 million increase in cash and investments resulting from $29.7 million in free cash flow plus a $45.3 million gain in the fair value of investment securities.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by that third party. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased $17.6 million in 2017. This is entirely due to a $19.5 million increase in accounts receivable from higher fourth quarter royalty revenue, partially offset by a reduction in deferred taxes. Changes in operating assets from year to year are largely due to timing of cash receipts and payments.

Property and equipment net book value decreased $1.7 million, as $10.7 million in new capital assets was exceeded by annual depreciation and amortization of existing capital assets.

Operating liabilities decreased slightly in 2017. One reason is in part due to favorable portfolio performance, which led to the pension liability being recorded as a prepaid expense.

AMA received tenant improvement allowances from new or renegotiated leases in Washington D.C. and New Jersey during 2017 and had received similar concessions in 2013 related to the headquarters building. The tenant improvement allowances are recorded as a deferred lease obligation and are amortized over the life of the individual leases.

Changes in deferred rent reflect the difference between the amounts recorded as expense and the amounts paid on all current leases. AMA records rent expense leases ratably over the period AMA took possession of the premises through the lease termination date. Amounts expensed but unpaid are considered a deferred rent obligation and will be reduced over the term of the lease.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

Cash flows

Cash and cash equivalents were up $19.1 million in 2017, and $4.7 million in the prior year. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash
(in millions)

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
</table>
| Free cash flow measures the AMA’s ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash in 2017 totaled $29.7 million, $10 million greater than the 2016 results, impacted by a one-time payment for a licensing agreement that will be recognized as revenue over future licensing periods.
The reserves and operating funds above do not include cash and investments in the for-profit subsidiaries, and reflect only the not-for-profit entity's cash and investment portfolio values.

As of year-end 2017, permanent reserves were $583.8 million compared to $510.8 million in 2016, a $73 million increase. That increase was the result of a $26.6 million transfer of 2016 excess operating funds to reserves plus a $46 million gain in the market value of the reserve portfolio. Operating funds totaled $72.2 million in 2017, down $16 million from 2016.

The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term pension and postretirement liabilities. Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all operating liabilities.

The minimum reserve portfolio level is designed to ensure that the AMA can always meet its long-term obligations for pension and postretirement health care, as well as provide that the AMA could continue operations for at least one year in the case of a catastrophic occurrence.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from the reserve funds is limited to the amount by which reserves exceed the minimum requirement. The Board of Trustees must authorize any use of reserves.
Membership
The Membership group’s total revenue includes both net membership dues and interest expense on lifetime memberships. Net membership dues is equal to the gross dues revenue collected, reduced by commissions paid to state societies, and is the membership dues revenue reported on the statement of activities.

The AMA achieved its seventh consecutive year of increases in the number of dues-paying members, although total dues revenue declined slightly in 2017. The number of dues paying members increased 1.8 percent in 2017, and total membership increased 1.2 percent and 2.6 percent in 2017 and 2016, respectively.

Gross dues revenue was $37.9 million, a $1.4 million decrease from 2016, as membership increased in categories with lower average dues rates, such as group practices, residents and sponsored memberships. Commissions and incentives paid to state societies totaled $0.1 million in 2016. Interest expense on lifetime memberships was $0.1 million in both 2017 and 2016.

Investments (AMA-only)
AMA-only investment income includes dividend and interest earnings on the AMA’s portfolio. Investment income in AMA’s active subsidiaries is included in the Publishing, Health Solutions and Insurance results.

Investments’ income was $10.7 million in 2017, a $1 million increase over the prior year, mainly due to an increase in the investable fund balances. Continued low interest rates have resulted in reduced levels of income in the portfolio during the last several years.

The net gain or loss on investments is not included in operating results, but reported as a non-operating item. This amount is in addition to the investment income discussed above, and totals a gain of $45.3 million in 2017, compared to a $24.1 million gain in 2016. The total investment return on the portfolio was 9.4 percent. The 2017 return compares to a composite benchmark index of 10.6 percent. AMA’s portfolio is balanced almost equally between equity and fixed income. AMA does not invest in passive index funds due to the prohibition on tobacco-related investing. Passive index funds have substantially outperformed active management for the last several years.

Other revenues
Other revenues are derived from grants and other fee income. These decreased $0.3 million in 2017, largely due to reduced grant income in the core activities.

Contribution margin (net expenses)
Contribution margin equals unit revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the unit, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.
The contribution margin generated by Membership, Publishing, Health Solutions and Insurance, as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization. Membership continues to provide over 13 percent of those funding needs.

Membership
Membership’s contribution margin decreased $2.7 million in 2017 due to the combination of a dues revenue decline, increased solicitation costs for marketing efforts and implementation of a digital marketing program for membership.

Investments (AMA-only)
The $0.8 million increase in contribution margin was largely due to the $1 million revenue improvement, slightly offset by increased costs associated with managing two reserve portfolios, one for core reserves and one for reserves in excess of the minimum required level. The latter portfolio will have a more aggressive asset allocation than the core portfolio.

Publishing, Health Solutions and Insurance
Publishing, Health Solutions and Insurance results were up $25.6 million in 2017. Royalty and credentialing revenue increases, offset by a decline in coding book sales volume and lower publishing revenue, were the major factors. Contribution margin declined $1.7 million in Publishing, as revenue losses in advertising and print subscriptions were somewhat offset by cost reductions put in place to mitigate the impact of the revenue decline.

Database Products reported a $4.8 million improvement due mainly to increased revenue but also the absence of additional costs for improving the quality of the physician masterfile incurred in the prior year.

Books and Digital Content contribution margin rose $23.3 million, largely on the strength of continued growth in royalties, offset by costs associated for a new CPT editorial system.

The Insurance Agency/Affinity Products margin was up slightly, with cost reductions more than compensating for the declining revenue.

The Integrated Health Model Initiative (IHMI) was launched in 2017 and is a platform for bringing together the health and technology sectors around a common data model. A common data model for the health system can collect, organize, exchange and analyze critical data elements, equipping clinicians with essential information to shift care plans towards achieving outcomes that are more relevant to a patient’s quality of life and consistent with the patient’s lifestyle, goals, and health status. Given the high economic and societal burden of chronic diseases, IHMI will initially prioritize its resources and efforts in clinical areas such as hypertension, diabetes and asthma.

Other business operations margin was largely unchanged.

Strategic Focus Areas and Core Operations
The Strategic Focus Areas include direct costs associated with the units for Improving Health Outcomes (IHO), Accelerating Change in Medical Education (ACE), and Enhancing Professional Satisfaction and Practice Sustainability (PS2).

IHO involves AMA focusing on two of the nation’s most prevalent issues: cardiovascular disease and type 2 diabetes, and setting a course of innovation and action to develop, enhance and implement strategies aimed at reducing the
disease and cost burden associated with these selected conditions. More than 400 medical practices, providers and health systems are now participating in Target: BP, the joint national initiative of the AMA and the American Heart Association (AHA), aimed at reducing the number of American adults who die from heart attacks and strokes every year.

To help prevent type 2 diabetes, the AMA and the Centers for Disease Control and Prevention (CDC) developed a toolkit to help health care teams screen, test and refer at risk patients to in-person or online diabetes prevention programs (DPP’s). The AMA is also partnering with the CDC and YMCA to increase physician screening and testing of patients for prediabetes as well as working to achieve coverage for diabetes prevention programs, after AMA's success in expanding the Medicare DPP coverage.

Through ACE, in 2013 the AMA launched a multi-year $11 million grant program with 11 medical schools aimed at bringing innovative changes to medical education. The consortium of schools was expanded later by an additional 21 schools selected from more than 100 medical schools that applied. A critical component of this initiative was the establishment of a learning collaborative so that best practices can be developed, shared and implemented in medical schools across the country.

To fully serve patients today and into the future, physicians need to understand the content of health systems science. This new discipline includes understanding how to improve health care quality, increase the value of care provided, enhance patient safety, deliver population-based medical care and work collaboratively in teams. AMA’s Accelerating Change in Medical Education Consortium, with Health Systems Science, has created the first textbook that focuses on providing a fundamental understanding of how health care is delivered, how health care professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In PS2, the AMA is investing significant resources in evaluating a path to long-term sustainability of and satisfaction with medical practice. The goals of this initiative are to promote successful models in both the public and private sectors; create tools focused on helping physicians implement practice improvements; improving the usability of electronic health records, shaping the evolution of payment models for sustainability and satisfaction, and promoting physician representation and leadership in the governance structure of hospitals and health systems. The AMA's STEPS Forward™ practice transformation series is a collection of interactive, educational modules developed by physicians to help physicians address common challenges in their practices. A variety of the modules focuses on preventing physician burnout.

The AMA also offers many opportunities for physicians to enhance their leadership skills and engage in leadership opportunities. Identifying key challenges physicians face with health IT and focusing on improved usability and interoperability is another major initiative. The digital health strategy will continue to focus on research, initiatives, and strategic partnerships that aim to improve health care technology and help physicians influence and adopt digital health solutions. As a dues paying member and founder of Xcertia, Sequoia/Carequality and the CARIN Alliance, AMA helps lead in the area of interoperability.

The Strategic Focus Areas continued to expand staff and operations during 2017, the fifth full year of implementation of AMA's new strategic plan. Most of the $3.3 million net expense increase in 2017 was due to marketing expenses in hypertension and pre-diabetes programs as well as a final payment on a grant to assist in the development of a teaching electronic medical record (tEMR).

Core Operations includes three groups: Advocacy; Health, Science and Core Medical Education; and Communications and Marketing.

The Advocacy Group includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. In 2017, Advocacy net spending totaled $26.5 million, up $2.1 million from the prior year, reflecting costs related to the 2017 campaign advocating support of AMA health system reform objectives and opposing the AHCA. Continuing efforts to reduce onerous rules for implementation of MACRA, establishment of a national task force to engage physicians to curb opioid abuse, convening a task force on MACRA adoption and research on prior authorization, to name a few, also increased costs in 2017.

Health, Science and Core Medical Education includes Science; Core Medical Education; Ethics; and Grants. The group is involved in developing AMA policies on scientific issues for the House of Delegates (HOD); public health advocacy; defining or influencing standards for undergraduate, graduate and continuing medical education; establishing and disseminating ethical standards for the profession; enhancing quality of care and patient safety; and providing support for the Councils on Ethical and Judicial Affairs, Science and Public Health and Medical Education. In 2016, this group successfully spearheaded the adoption of the modernized AMA Code of Medical Ethics. A major initiative for this group is education delivery services for the education center, providing a digital platform for lifelong professional development, which caused a $1 million net expense increase in Health, Science and Core
Medical Education. The remaining increase is largely due to support for the campaign to expand GME slots.

Communications and Marketing focuses its efforts on enhancing the AMA’s brand image; informing the public about the AMA’s positions and policies; supporting the AMA’s advocacy efforts and maintaining effective member communications. Net expenses were up $5.4 million in 2017, mainly due to continued higher spending on major initiatives, the brand and Membership Moves Medicine campaigns. AMA continues to sponsor major health care events such as TEDMED and Health 2.0 challenges as part of its influencer campaign.

**Governance**

Governance includes the Board of Trustees and Officer Services, the HOD, Sections and Special Constituencies and International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Focus Areas and Core Operations. The HOD, Sections and Special Constituencies and International unit includes costs associated with annual and interim meetings, groups and sections and other HOD activities, as well as costs associated with AMA’s involvement in the World Medical Association.

In 2017, Governance net spending increased $0.8 million, with a $0.5 million increase in the Board of Trustees unit and a $0.3 million increase in the HOD and Sections and Special Constituencies and International unit.

**Administration and operations**

These units provide administrative and operational support for Publishing, Health Solutions and Insurance, Membership and all other operating groups. Net expenses increased by $4.3 million in 2017, or 6.2 percent. The Physician Engagement and Portfolio Management unit was expanded in 2017 to add digital marketing and enhanced physician outreach, causing a $3 million net expense increase. This expansion is focused on improving the customer experience, reaching our members based on their interests and substantially enhancing communication of AMA’s important contributions to physicians’ professional life and the health care system. Senior Executive Management costs were up $1.8 million of which $0.9 million was due to contributions for disaster relief in areas impacted by hurricanes. The majority of the remaining cost increase was due to expanded use of third party consultants on major new initiatives.

**Affiliated organizations**

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. Net expenses were unchanged in 2017.

**Unallocated overhead**

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2017, these expenses totaled $16.8 million, up from $15.2 million in 2016. Higher incentive compensation accounted for the entire increase.

**Health2047**

In 2015, the AMA Board approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding key projects in future years.

Health2047 is a Silicon Valley-based innovation enterprise developing and commercializing solutions in the areas of data liquidity, chronic care, productivity, and payments to significantly change U.S. healthcare at the system level.

Health2047 will provide strategic insights through privileged access to the AMA and its physician network, help execute in product development and bring massive channel strength, all within a culture that can rapidly innovate and have the capacity to pursue multiple products and create a portfolio.

The innovation studio began operations in mid-2015 with a formal launch of the studio in early 2016. Development of initial projects is underway with strong market interest expressed by major corporations. In 2017, Health2047 spun out a new company, Health2047 SwitchCo, Inc. (doing business as Akiri in 2018), in order to commercialize efforts to build and deploy trusted infrastructure for permissions-based secure transport of health data. AkiriSwitch (the platform name) employs blockchain technology. Akiri began with a Series A investment, a core group of founding executives, and significant market interest in its open approach to building trusted infrastructure for private data transport. Akiri has quickly built out its engineering bench, attracting key engineering talent from recognized market innovators. The $10.4 million in net expenses reflects the results of both companies.

The summary of group operating results is included on the following page.
# American Medical Association group operating results

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Membership</strong></td>
<td>$37.8</td>
<td>$39.1</td>
<td>$25.3</td>
<td>$28.0</td>
</tr>
<tr>
<td><strong>Publishing, Health Solutions and Insurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publishing</td>
<td>59.3</td>
<td>61.8</td>
<td>7.8</td>
<td>9.5</td>
</tr>
<tr>
<td>Database Products</td>
<td>55.4</td>
<td>51.8</td>
<td>44.6</td>
<td>39.8</td>
</tr>
<tr>
<td>Books and Digital Content</td>
<td>138.8</td>
<td>115.2</td>
<td>117.9</td>
<td>94.6</td>
</tr>
<tr>
<td>Insurance Agency/Affinity Products</td>
<td>38.9</td>
<td>39.1</td>
<td>21.0</td>
<td>20.9</td>
</tr>
<tr>
<td>Integrated Health Model Initiative</td>
<td>-</td>
<td>-</td>
<td>(2.5)</td>
<td>(1.4)</td>
</tr>
<tr>
<td>Other business operations</td>
<td>-</td>
<td>-</td>
<td>(2.1)</td>
<td>(2.3)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>292.4</td>
<td>267.9</td>
<td>186.7</td>
<td>161.1</td>
</tr>
<tr>
<td><strong>Investments (AMA-only)</strong></td>
<td>10.7</td>
<td>9.7</td>
<td>9.9</td>
<td>9.1</td>
</tr>
<tr>
<td><strong>Strategic Focus Areas and Core Operations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Focus Areas</td>
<td>0.4</td>
<td>0.5</td>
<td>(24.5)</td>
<td>(21.2)</td>
</tr>
<tr>
<td>Advocacy</td>
<td>0.6</td>
<td>0.7</td>
<td>(26.5)</td>
<td>(24.4)</td>
</tr>
<tr>
<td>Health, Science and Core Medical Education</td>
<td>4.4</td>
<td>4.7</td>
<td>(11.3)</td>
<td>(9.7)</td>
</tr>
<tr>
<td>Communications and Marketing</td>
<td>-</td>
<td>-</td>
<td>(22.1)</td>
<td>(16.7)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5.4</td>
<td>5.9</td>
<td>(84.4)</td>
<td>(72.0)</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board of Trustees and Officer Services</td>
<td>-</td>
<td>-</td>
<td>(6.1)</td>
<td>(5.6)</td>
</tr>
<tr>
<td>House of Delegates, Sections, Special Constituencies and International</td>
<td>0.1</td>
<td>0.1</td>
<td>(8.0)</td>
<td>(7.7)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.1</td>
<td>0.1</td>
<td>(14.1)</td>
<td>(13.3)</td>
</tr>
<tr>
<td><strong>Administration and Operations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Technology</td>
<td>-</td>
<td>-</td>
<td>(28.1)</td>
<td>(29.5)</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>-</td>
<td>-</td>
<td>(5.8)</td>
<td>(5.6)</td>
</tr>
<tr>
<td>Senior Executive Management</td>
<td>-</td>
<td>-</td>
<td>(7.0)</td>
<td>(5.2)</td>
</tr>
<tr>
<td>Physician Engagement/Portfolio Management</td>
<td>-</td>
<td>-</td>
<td>(14.2)</td>
<td>(11.2)</td>
</tr>
<tr>
<td>General Counsel</td>
<td>-</td>
<td>-</td>
<td>(5.1)</td>
<td>(5.0)</td>
</tr>
<tr>
<td>Finance and Risk Management</td>
<td>-</td>
<td>-</td>
<td>(6.7)</td>
<td>(6.6)</td>
</tr>
<tr>
<td>Human Resources</td>
<td>-</td>
<td>-</td>
<td>(5.1)</td>
<td>(4.7)</td>
</tr>
<tr>
<td>Strategic Planning and Health Analytics</td>
<td>-</td>
<td>-</td>
<td>(2.0)</td>
<td>(1.9)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>-</td>
<td>(74.0)</td>
<td>(69.7)</td>
</tr>
<tr>
<td><strong>Affiliated Organizations</strong></td>
<td>0.1</td>
<td>-</td>
<td>(0.1)</td>
<td>(0.1)</td>
</tr>
<tr>
<td><strong>Unallocated Overhead</strong></td>
<td>1.0</td>
<td>1.0</td>
<td>(16.8)</td>
<td>(15.2)</td>
</tr>
<tr>
<td><strong>Consolidated – excluding Health2047</strong></td>
<td>347.5</td>
<td>323.7</td>
<td>32.5</td>
<td>27.9</td>
</tr>
<tr>
<td><strong>Health2047</strong></td>
<td>0.1</td>
<td>-</td>
<td>(10.4)</td>
<td>(6.6)</td>
</tr>
<tr>
<td><strong>Consolidated</strong></td>
<td>$347.6</td>
<td>$323.7</td>
<td>$22.1</td>
<td>$21.3</td>
</tr>
</tbody>
</table>
2017
CONSOLIDATED
FINANCIAL
STATEMENTS
American Medical Association and subsidiaries  
CONSOLIDATED STATEMENTS OF ACTIVITIES  
Years ended December 31

<table>
<thead>
<tr>
<th>(in millions)</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership dues</td>
<td>$37.9</td>
<td>$39.2</td>
</tr>
<tr>
<td>Advertising</td>
<td>14.1</td>
<td>17.3</td>
</tr>
<tr>
<td>Periodical print subscription revenues</td>
<td>5.2</td>
<td>6.0</td>
</tr>
<tr>
<td>Periodical online revenues</td>
<td>26.2</td>
<td>24.7</td>
</tr>
<tr>
<td>Other publishing revenue</td>
<td>12.8</td>
<td>12.8</td>
</tr>
<tr>
<td>Books, newsletters and online product sales</td>
<td>31.8</td>
<td>35.9</td>
</tr>
<tr>
<td>Royalties and credentialing products</td>
<td>162.3</td>
<td>131.7</td>
</tr>
<tr>
<td>Insurance commissions</td>
<td>35.8</td>
<td>36.0</td>
</tr>
<tr>
<td>Investment income (Note 4)</td>
<td>11.0</td>
<td>9.8</td>
</tr>
<tr>
<td>Grants and other income</td>
<td>10.5</td>
<td>10.3</td>
</tr>
<tr>
<td><strong>Total revenues</strong></td>
<td>347.6</td>
<td>323.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Expenses</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of products sold and selling expenses</td>
<td>28.2</td>
<td>30.1</td>
</tr>
<tr>
<td><strong>Contribution to general and administrative expenses</strong></td>
<td>319.4</td>
<td>293.6</td>
</tr>
</tbody>
</table>

| **General and administrative expenses** |       |       |
| Compensation and benefits | 171.0 | 162.0 |
| Occupancy | 18.4 | 17.4 |
| Travel and meetings | 14.4 | 13.1 |
| Technology costs | 23.0 | 21.2 |
| Marketing and promotion | 20.0  | 11.3  |
| Professional services and consulting | 28.7  | 29.0  |
| Other operating expenses | 21.8  | 18.3  |
| **Total general and administrative expenses** | 297.3 | 272.3 |

| **Operating results before income taxes** | 22.1  | 21.3  |
| Income taxes (Note 9) | 8.3  | 7.7  |
| **Net operating results** | 13.8  | 13.6  |

| **Non-operating items** |       |       |
| Net gain on investments (Note 4) | 45.3  | 24.1  |
| Other | 0.1 | - |
| **Total non-operating items** | 45.4  | 24.1  |

| **Revenues in excess of expenses** | 59.2  | 37.7  |
| Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 7, 8 and 9) | 11.4  | 0.4  |
| **Change in association equity – unrestricted** | 70.6  | 38.1  |

| **Change in temporarily restricted association equity** |       |       |
| Restricted contributions | 0.3  | 0.3  |
| Net assets released from restriction | (0.2)  | (0.4)  |
| **Change in association equity – temporarily restricted** | 0.1  | (0.1)  |
| **Change in association equity** | 70.7  | 38.0  |
| Association equity at beginning of year | 489.0  | 451.0  |
| **Association equity at end of year** | $559.7 | $489.0 |

See accompanying notes to the consolidated financial statements.
American Medical Association and subsidiaries

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

As of December 31

<table>
<thead>
<tr>
<th>(in millions)</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$48.0</td>
<td>$28.9</td>
</tr>
<tr>
<td>Fiduciary funds (Note 2)</td>
<td>20.1</td>
<td>21.2</td>
</tr>
<tr>
<td>Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.1 in 2017 and 2016</td>
<td>59.6</td>
<td>40.1</td>
</tr>
<tr>
<td>Inventories</td>
<td>2.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>5.9</td>
<td>5.3</td>
</tr>
<tr>
<td>Deferred income taxes (Note 9)</td>
<td>4.4</td>
<td>6.8</td>
</tr>
<tr>
<td>Investments (Note 4)</td>
<td>653.4</td>
<td>597.4</td>
</tr>
<tr>
<td>Property and equipment, net (Note 6)</td>
<td>47.1</td>
<td>48.8</td>
</tr>
<tr>
<td>Prepaid pension costs (Note 8)</td>
<td>1.1</td>
<td>-</td>
</tr>
<tr>
<td>Other assets (Note 5)</td>
<td>6.8</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$848.7</td>
<td>$756.3</td>
</tr>
<tr>
<td><strong>Liabilities, deferred revenue and association equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>$16.7</td>
<td>$15.9</td>
</tr>
<tr>
<td>Accrued payroll and employee benefits (Notes 7 and 8)</td>
<td>135.9</td>
<td>139.6</td>
</tr>
<tr>
<td>Insurance premiums and other fiduciary funds payable</td>
<td>20.5</td>
<td>20.7</td>
</tr>
<tr>
<td>Income taxes payable (Note 9)</td>
<td>1.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Deferred tenant improvement allowances (Note 10)</td>
<td>17.1</td>
<td>17.1</td>
</tr>
<tr>
<td>Deferred rent obligations (Note 11)</td>
<td>22.5</td>
<td>21.3</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>214.6</td>
<td>215.4</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership dues</td>
<td>17.0</td>
<td>18.3</td>
</tr>
<tr>
<td>Subscriptions, licensing and royalties</td>
<td>54.4</td>
<td>31.7</td>
</tr>
<tr>
<td>Grants and other</td>
<td>3.0</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total Deferred Revenue</strong></td>
<td>74.4</td>
<td>51.9</td>
</tr>
<tr>
<td>Association equity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>558.0</td>
<td>487.4</td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>1.7</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Total Association Equity</strong></td>
<td>559.7</td>
<td>489.0</td>
</tr>
<tr>
<td><strong>Total Liabilities, Deferred Revenue and Association Equity</strong></td>
<td>$848.7</td>
<td>$756.3</td>
</tr>
</tbody>
</table>

See accompanying notes to the consolidated financial statements.
### American Medical Association and subsidiaries

**CONSOLIDATED STATEMENTS CASH FLOWS**

Years ended December 31

(in millions)

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in association equity</td>
<td>$ 70.7</td>
<td>$ 38.0</td>
</tr>
<tr>
<td>Adjustments to reconcile change in association equity to net cash provided by operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>11.9</td>
<td>11.0</td>
</tr>
<tr>
<td>Pension and postretirement health care expense</td>
<td>8.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Net gain on investments</td>
<td>(45.3)</td>
<td>(24.1)</td>
</tr>
<tr>
<td>Noncash credit for changes in defined benefit postretirement plans other than periodic expense, net of tax</td>
<td>(11.4)</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Other</td>
<td>0.4</td>
<td>-</td>
</tr>
<tr>
<td>Changes in assets and liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable and other receivables</td>
<td>(19.5)</td>
<td>(5.1)</td>
</tr>
<tr>
<td>Fiduciary funds, net of payable</td>
<td>0.9</td>
<td>(0.5)</td>
</tr>
<tr>
<td>Inventories</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>(0.6)</td>
<td>0.8</td>
</tr>
<tr>
<td>Deferred income taxes</td>
<td>(0.6)</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Accounts payable, accrued liabilities and income taxes</td>
<td>1.4</td>
<td>-</td>
</tr>
<tr>
<td>Deferred rent obligations and tenant improvement allowances</td>
<td>1.2</td>
<td>(1.4)</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>22.5</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Net cash provided by operating activities</strong></td>
<td>40.0</td>
<td>29.5</td>
</tr>
</tbody>
</table>

| **Cash flows from investing activities** |       |       |
| Purchase of property and equipment | (10.3) | (9.8) |
| Purchase of investments | (331.7) | (404.3) |
| Proceeds from sale of investments | 321.1  | 389.3 |
| **Net cash used in investing activities** | (20.9) | (24.8) |

| **Net change in cash and cash equivalents** | 19.1  | 4.7   |
| Cash and cash equivalents at beginning of year | 28.9  | 24.2  |
| **Cash and cash equivalents at end of year** | $ 48.0 | $ 28.9 |

| **Noncash investing activities** |       |       |
| Accounts payable for property and equipment additions | $ 0.7 | $ 0.4 |

See accompanying notes to the consolidated financial statements.
1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 243 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all association results as revenues and expenses in the consolidated statements of activities, except non-operating items. Non-operating items include net realized and unrealized gains and losses on investments and other non-recurring income or expense.

Temporarily restricted equity includes contributions for physician liability reform and scope of practice. These funds are restricted for use to areas such as national tort reform campaign efforts and are not available for general use within the AMA.

2. Significant accounting policies

Consolidation policy
The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries (collectively, the AMA). In 2015, AMA established a new for-profit subsidiary, Health2047, designed to enhance AMA’s ability to contribute to improvements in the U.S. health care system and population health. In 2017, Health2047 established a new for-profit corporation, Health2047 SwitchCo, Inc. (SwitchCo), designed to improve the securing, sharing and use of trusted health data. As of December 31, 2017, Health2047 has consolidated the operations of SwitchCo. All significant intercompany transactions have been eliminated.

Use of estimates
Preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents
Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds
One of the AMA’s subsidiaries, the AMA Insurance Agency, Inc. (Agency), in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of a separate unincorporated entity with $2.4 million and $2.3 million held at December 31, 2017 and 2016, respectively.

Inventories
Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or market.

Property and equipment
Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation is computed using the straight-line method over the estimated useful lives of the assets. Equipment and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition
Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year. Dues from lifetime memberships are recognized as revenue over the approximate life of the member. Prepaid dues are included as deferred revenue in the consolidated statements of financial position.

Licensing and subscriptions to periodicals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related periodical is issued. Royalties are recognized as revenue over the royalty term.
In March 2017, the FASB issued ASU No. 2017-07, Compensation Retirement Benefits (Topic 715): Improving the Presentation of the Net Periodic Cost and Net Periodic Postretirement Benefit Cost (ASU No. 2017-07). This requires an employer to report the service cost component of retirement benefits in the same line item or items as the other compensation costs arising from services rendered by the pertinent employees during the period while the other components of net benefit costs will be presented in the income statement separately from the service cost component and outside a subtotal of income from operations. ASU No. 2017-07 is effective for the AMA for years beginning after December 15, 2018, but early adoption is permitted. The AMA plans to adopt this standard in 2018 and estimates that approximately $3 million of pension expense and approximately $4 million of postretirement healthcare expense will be reclassified from operating expense to a separate line in non-operating expenses in the year of adoption. There will be no impact on the consolidated statements of financial position.

4. Investments

Investments include marketable securities and a private equity investment that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's ASC Topic 820, Fair Value Measurements and Disclosures, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.
Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

Foreign and state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity, and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout opportunities in the United States and the European Union. The investment is not redeemable and distributions are received through liquidation of the underlying assets of the fund. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment manager. Unfunded commitments as of December 31, 2017 totaled $22.9 million.

The following table presents information about the AMA's investments measured at fair value as of December 31.

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity securities</td>
<td>312.1</td>
<td>271.4</td>
</tr>
<tr>
<td>Fixed-income mutual funds</td>
<td>15.6</td>
<td>13.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>327.7</td>
<td>284.5</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>90.4</td>
<td>82.0</td>
</tr>
<tr>
<td>U.S. government and federal agency</td>
<td>200.7</td>
<td>202.4</td>
</tr>
<tr>
<td>Foreign government</td>
<td>30.0</td>
<td>26.8</td>
</tr>
<tr>
<td>U.S. state government</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>321.4</td>
<td>311.6</td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unobservable inputs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Other investments measured at NAV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private equity fund</td>
<td>4.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Investments</td>
<td>653.4</td>
<td>597.4</td>
</tr>
</tbody>
</table>

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.
Investment income consists of:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment dividend and interest income</td>
<td>$13.5</td>
<td>$12.0</td>
</tr>
<tr>
<td>Management fees</td>
<td>(2.5)</td>
<td>(2.2)</td>
</tr>
</tbody>
</table>

$11.0 $9.8

Non-operating items include:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Realized gains on investments, net</td>
<td>$12.0</td>
<td>$1.0</td>
</tr>
<tr>
<td>Unrealized gains on investments, net</td>
<td>33.3</td>
<td>23.1</td>
</tr>
</tbody>
</table>

$45.3 $24.1

5. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $6.8 million and $5.4 million at 2017 and 2016, respectively.

6. Property and equipment

Property and equipment at December 31 consists of:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leasehold improvements</td>
<td>$35.9</td>
<td>$34.3</td>
</tr>
<tr>
<td>Furniture and office equipment</td>
<td>18.2</td>
<td>17.6</td>
</tr>
<tr>
<td>Information technology hardware and software</td>
<td>99.4</td>
<td>93.3</td>
</tr>
</tbody>
</table>

153.5 145.2

Accumulated depreciation and amortization

(106.4) (96.4)

$47.1 $48.8

7. Retirement pension and savings plans

The AMA has a defined benefit pension plan covering eligible salaried and hourly employees. The plan is designed to pay a monthly retirement benefit that, together with Social Security benefits, provides retirement income based on employees’ earnings, age and years of service. Other employers participate in this plan and assets and liabilities are allocated between the AMA and the other employers.

The AMA amended the pension plan to freeze pension benefits as of December 31, 2002. After that date, no individual can become a participant in the plan and no further benefits accrue under the plan. Individuals not vested as of that date were credited for future years of service for vesting purposes only. As a result, the projected benefit obligation is equal to the accumulated benefit obligation for this plan.

The changes in benefit obligation and plan assets were as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit obligation at beginning of year</td>
<td>$123.6</td>
<td>122.3</td>
</tr>
<tr>
<td>Interest cost</td>
<td>4.5</td>
<td>4.7</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>(6.6)</td>
<td>(5.3)</td>
</tr>
<tr>
<td>Actuarial loss</td>
<td>2.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Benefit obligation at end of year</td>
<td>$124.0</td>
<td>123.6</td>
</tr>
</tbody>
</table>

Change in plan assets

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair value of plan assets at beginning of year</td>
<td>$119.5</td>
<td>119.4</td>
</tr>
<tr>
<td>Return on plan assets</td>
<td>12.2</td>
<td>5.4</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>(6.6)</td>
<td>(5.3)</td>
</tr>
<tr>
<td>Fair value of plan assets at end of year</td>
<td>$125.1</td>
<td>119.5</td>
</tr>
</tbody>
</table>

The funded status and amounts recognized in the AMA’s consolidated statements of financial position at December 31 are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair value of plan assets</td>
<td>$125.1</td>
<td>119.5</td>
</tr>
<tr>
<td>Projected benefit obligation</td>
<td>124.0</td>
<td>123.6</td>
</tr>
<tr>
<td>Prepaid (accrued) pension costs</td>
<td>$1.1</td>
<td>(4.1)</td>
</tr>
</tbody>
</table>

In accordance with ASC Topic 958-715, Employers’ Accounting for Defined Benefit Pension and Other Postretirement Plans, all previously unrecognized actuarial losses are reflected in the consolidated statements of financial position. Accumulated amounts recognized in unrestricted equity that are not yet recognized as a component of periodic pension expense are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial losses</td>
<td>$37.0</td>
<td>$45.1</td>
</tr>
</tbody>
</table>

An estimated $3.6 million of this amount will be included as a component of pension expense in 2017.

The weighted-average assumptions used in determining the December 31 benefit obligations were:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>3.4%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>
The AMA recognizes pension expense in its consolidated statements of activities. The provisions of ASC Topic 958-715 require the AMA to recognize settlement charges based on the lump-sum benefit payments in 2017 and 2016. The components of pension expense are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest cost</td>
<td>$4.5</td>
<td>$4.7</td>
</tr>
<tr>
<td>Expected return on plan assets</td>
<td>(6.9)</td>
<td>(6.9)</td>
</tr>
<tr>
<td>Lump-sum settlement charges</td>
<td>1.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Recognized actuarial loss</td>
<td>3.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Pension expense</td>
<td>$2.9</td>
<td>$3.1</td>
</tr>
</tbody>
</table>

Pension-related changes, other than periodic pension expense, that have been included as a charge or credit to unrestricted equity consist of:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial gains (losses) arising during period</td>
<td>$2.8</td>
<td>$(3.4)</td>
</tr>
<tr>
<td>Reclassification adjustment for losses reflected in periodic pension expense</td>
<td>5.3</td>
<td>5.3</td>
</tr>
<tr>
<td>Change in unrestricted equity</td>
<td>$8.1</td>
<td>$1.9</td>
</tr>
</tbody>
</table>

Actuarial assumptions used in determining pension expense were:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>3.8%</td>
<td>4%</td>
</tr>
<tr>
<td>Expected long-term return on plan assets</td>
<td>5.75%</td>
<td>5.75%</td>
</tr>
</tbody>
</table>

To develop the expected long-term rate of return on plan assets for the pension plan, the AMA considered the current level of expected returns on risk-free investments (primarily government bonds), the historical level of risk premium associated with the other asset classes in which the portfolio is invested and the expectations for future returns of each asset class. The expected return for each asset class is then weighted based on the target asset allocation to develop the expected long-term rate of return on assets assumption for the portfolio. The AMA’s investment strategy reflects the expectation that equity securities will outperform debt securities over the long term. Assets are invested in a prudent manner to maintain the security of funds while maximizing returns within the plan’s investment policy guidelines. The strategy is implemented utilizing actively managed assets from the categories listed below.

The investment goal is to provide a total return that, over the long term, increases the ratio of plan assets to liabilities subject to an acceptable level of risk. This is accomplished through diversification of assets in accordance with the investment policy. Periodic rebalancing occurs after the end of each calendar quarter, as required by the policy.

The target allocations for plan assets are 45 percent equity securities, 50 percent corporate bonds and U.S. Treasury or Agency securities, and 5 percent in cash and cash equivalents.

Equity securities include investments in large-cap, mid-cap, and small-cap companies primarily located in the United States and large- to mid-cap companies outside the United States through investments in mutual funds.

Mutual funds are open-ended SEC registered investment funds with a daily NAV.

Fixed-income securities include primarily investment grade corporate bonds of companies from diversified industries and U.S. Treasury or Agency securities and foreign government securities, either through direct investment in bonds or through common trusts, as well as an allocation to high-yield U.S. corporate bonds, with a target of 4 percent of the portfolio.

The following fair value hierarchy tables present information about the AMA pension plan investments measured at fair value as of December 31.

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 – Quoted prices in active markets for identical securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. equity securities</td>
<td>$45.8</td>
<td>$42.8</td>
</tr>
<tr>
<td>International mutual funds</td>
<td>9.5</td>
<td>9.0</td>
</tr>
<tr>
<td>Fixed-income mutual funds</td>
<td>37.1</td>
<td>36.4</td>
</tr>
<tr>
<td>High-yield fixed income mutual fund</td>
<td>5.1</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td>97.5</td>
<td>93.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2 – Significant other observable inputs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>9.8</td>
<td>9.6</td>
</tr>
<tr>
<td>U.S. government and agency</td>
<td>16.7</td>
<td>15.7</td>
</tr>
<tr>
<td>Foreign government</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td></td>
<td>27.6</td>
<td>26.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3 – Significant unobservable inputs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marketable investments – all levels</td>
<td>$125.1</td>
<td>$119.5</td>
</tr>
</tbody>
</table>

The AMA currently anticipates making no contribution to the pension plan in 2018, as plan assets are greater than the target of 110 percent of liabilities as calculated for funding purposes. This estimate is based on current tax laws, plan asset performance and liability assumptions, which are subject to change. Any shortfall in plan asset performance from the expected rate of return, or increase in plan liabilities due to lower interest rates, could cause contributions to increase by an amount equivalent to the shortfall in performance or increase in the present value of plan liabilities.
The following pension benefit payments are expected:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$9.0</td>
</tr>
<tr>
<td>2019</td>
<td>9.0</td>
</tr>
<tr>
<td>2020</td>
<td>9.9</td>
</tr>
<tr>
<td>2021</td>
<td>7.7</td>
</tr>
<tr>
<td>2022</td>
<td>8.2</td>
</tr>
<tr>
<td>2023 – 2027</td>
<td>37.3</td>
</tr>
</tbody>
</table>

The AMA also has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first 3 percent and 50 percent of the next 2 percent of employee contributions. The AMA may, in its discretion, make additional contributions for any year in an amount up to 2 percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $5.6 million and $5.3 million in 2017 and 2016, respectively.

The AMA also maintains a non-qualified, unfunded supplemental pension plan for certain long-term employees. Participation in the plan was closed in 1994. The AMA recognizes the liability in its consolidated statements of financial position. The accumulated benefit obligation and liability totaled $0.4 million in 2017 and 2016. The AMA uses the same discount rates noted above for the pension plan to determine the plan benefit obligation. There was no associated expense for this plan in 2017 and 2016. There was no changes in pension actuarial losses that are not yet reflected in periodic pension expense, but included in unrestricted equity in 2017 and 2016.

The AMA expects to pay approximately $0.4 million in benefits from the supplemental pension plan over the next five years.

8. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with provisions similar to the AMA’s pension plan and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and assets and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. In accordance with ASC Topic 958-715, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in benefit obligation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit obligation at beginning of year</td>
<td><strong>$106.4</strong></td>
<td>$100.7</td>
</tr>
<tr>
<td>Service cost</td>
<td>1.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Interest cost</td>
<td>4.0</td>
<td>4.3</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>(3.6)</td>
<td>(3.5)</td>
</tr>
<tr>
<td>Participant contributions</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Federal subsidy</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Plan amendments</td>
<td>(2.8)</td>
<td>-</td>
</tr>
<tr>
<td>Actuarial (gains) losses</td>
<td>(3.8)</td>
<td>1.8</td>
</tr>
<tr>
<td>Accrued postretirement benefit costs</td>
<td><strong>$103.1</strong></td>
<td>$106.4</td>
</tr>
</tbody>
</table>

The postretirement health care plan accumulated losses and prior service credits not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge or credit to equity as of December 31 are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial losses</td>
<td><strong>$21.0</strong></td>
<td>$25.3</td>
</tr>
<tr>
<td>Prior service credits</td>
<td>(3.5)</td>
<td>(1.5)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$17.5</strong></td>
<td>$23.8</td>
</tr>
</tbody>
</table>

An estimated $1 million in prior service credits and $1.2 million of actuarial losses will be included as components of postretirement health care expense in 2018.

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>3.7%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Initial health care cost trend</td>
<td><strong>6.22%</strong></td>
<td>6.39%</td>
</tr>
<tr>
<td>Ultimate health care cost trend</td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Year that the rate reaches the ultimate trend rate</td>
<td><strong>2038</strong></td>
<td>2038</td>
</tr>
</tbody>
</table>
The AMA recognizes postretirement health care expense in its consolidated statements of activities. The components of expense are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service cost</td>
<td>$1.7</td>
<td>$1.9</td>
</tr>
<tr>
<td>Interest cost</td>
<td>4.0</td>
<td>4.3</td>
</tr>
<tr>
<td>Recognized actuarial loss</td>
<td>0.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Amortization of prior service credits</td>
<td>(0.8)</td>
<td>(1.0)</td>
</tr>
<tr>
<td>Postretirement health care expense</td>
<td>$5.4</td>
<td>$6.2</td>
</tr>
</tbody>
</table>

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial gains (losses) arising during period</td>
<td>$3.8</td>
<td>$(1.8)</td>
</tr>
<tr>
<td>Reclassification adjustment for losses reflected in periodic postretirement health care expense</td>
<td>0.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Plan amendments</td>
<td>2.8</td>
<td>-</td>
</tr>
<tr>
<td>Reclassification adjustment for recognition of prior service credits</td>
<td>(0.8)</td>
<td>(1.0)</td>
</tr>
<tr>
<td>Change in unrestricted equity</td>
<td>$6.3</td>
<td>$(1.8)</td>
</tr>
</tbody>
</table>

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>4.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Initial health care cost trend</td>
<td>6.39%</td>
<td>6.55%</td>
</tr>
<tr>
<td>Year that the rate reaches the ultimate trend rate</td>
<td>2038</td>
<td>2038</td>
</tr>
</tbody>
</table>

A one-percentage point change in assumed health care cost rates would have the following effect:

<table>
<thead>
<tr>
<th></th>
<th>1% Increase</th>
<th>1% Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effect on postretirement service and interest cost</td>
<td>$1.3</td>
<td>$(1.0)</td>
</tr>
<tr>
<td>Effect on postretirement benefit obligation</td>
<td>$21.8</td>
<td>$(17.0)</td>
</tr>
</tbody>
</table>

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$2.3</td>
</tr>
<tr>
<td>2019</td>
<td>2.6</td>
</tr>
<tr>
<td>2020</td>
<td>2.8</td>
</tr>
<tr>
<td>2021</td>
<td>3.0</td>
</tr>
<tr>
<td>2022</td>
<td>3.2</td>
</tr>
<tr>
<td>2023 - 2027</td>
<td>19.5</td>
</tr>
</tbody>
</table>

9. Income taxes

The provision for income taxes includes:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>$8.9</td>
<td>$8.1</td>
</tr>
<tr>
<td>Deferred</td>
<td>0.6</td>
<td>(0.9)</td>
</tr>
<tr>
<td>Valuation allowance</td>
<td>(1.2)</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.3</td>
</tr>
<tr>
<td>Tax expense (credit) related to credits or charges to equity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred</td>
<td>3.0</td>
<td>(0.3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11.3</td>
</tr>
</tbody>
</table>

As prescribed under ASC Topic 740, Income Taxes, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or charge from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for both the pension and postretirement health care plans, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The AMA established an initial valuation allowance in 2009 to reflect the fact that deferred tax assets include future expected benefits, largely related to retiree health care payments, that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Operating tax expense was not materially impacted by changes in the tax law, as a reduction in deferred tax assets of $1.3 million was offset by an equivalent reduction in the valuation allowance. Tax expense related to credits to equity increased by $2 million with an offsetting reduction in deferred tax assets as a result of the change in tax law.
Deferred tax assets recognized in the consolidated statements of financial position at December 31 are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit plans and compensation</td>
<td>$6.9</td>
<td>$11.0</td>
</tr>
<tr>
<td>Other</td>
<td>0.4</td>
<td>(0.1)</td>
</tr>
<tr>
<td>Valuation allowance</td>
<td>(2.9)</td>
<td>(4.1)</td>
</tr>
<tr>
<td></td>
<td>$4.4</td>
<td>$6.8</td>
</tr>
</tbody>
</table>

Cash payments for income taxes were $7.8 million and $8.5 million in 2017 and 2016, respectively.

### 10. Deferred tenant improvement allowances

As part of the new headquarters lease agreement that commenced in 2013, the AMA received a total of $21.7 million tenant improvement allowance from the landlord in 2012 and 2013. In 2016, AMA renegotiated its office lease in Washington D.C. and received $1.4 million in new tenant allowances. This is in addition to the initial $2.1 million tenant allowance related to the Washington D.C. office space received in 2007. A new lease in New Jersey that was effective in 2017 included $0.2 million in tenant allowances.

Tenant improvement allowances are recorded as a deferred liability on the consolidated statements of financial position and as a cash inflow from operating activities in the consolidated statements of cash flows. Capital expenditures funded by the tenant improvement allowances received are capitalized as leasehold improvements on the consolidated statements of financial position and as capital expenditures in the consolidated statements of cash flows. The tenant allowances are deferred and amortized on a straight-line basis over the life of the leases as a reduction of rent expense.

### 11. Deferred rent obligations

The headquarters lease agreement included rent abatement through August 2015 as well as rent escalation clauses over the life of the lease. The Washington D.C. and New Jersey office leases also include rent abatement and escalation clauses. AMA is required to recognize rent expense on a straight-line basis beginning on the earlier of the first rent payment or the date of possession of the leased property. The difference between the amounts charged to expense and the rent paid is recorded as a deferred rent obligation and amortized over the lease term.

### 12. Commitments and contingencies

#### Lease commitments

Rent expense under operating leases, including executory costs and taxes, was $13.3 million and $12.8 million in 2017 and 2016, respectively. Future minimum lease payments as of December 31, 2017 are:

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$10.6</td>
</tr>
<tr>
<td>2019</td>
<td>11.4</td>
</tr>
<tr>
<td>2020</td>
<td>11.6</td>
</tr>
<tr>
<td>2021</td>
<td>11.7</td>
</tr>
<tr>
<td>2022</td>
<td>11.7</td>
</tr>
<tr>
<td>2023 and beyond</td>
<td>76.3</td>
</tr>
<tr>
<td>Total</td>
<td>$133.3</td>
</tr>
</tbody>
</table>

All leases have renewal options.

#### Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.
### 13. Functional expenses

<table>
<thead>
<tr>
<th>Category</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>$12.5</td>
<td>$11.1</td>
</tr>
<tr>
<td>Publishing, health solutions, and insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publishing</td>
<td>51.5</td>
<td>52.3</td>
</tr>
<tr>
<td>Database products</td>
<td>10.8</td>
<td>12.0</td>
</tr>
<tr>
<td>Book and digital content</td>
<td>20.9</td>
<td>20.6</td>
</tr>
<tr>
<td>Insurance agency</td>
<td>17.9</td>
<td>18.2</td>
</tr>
<tr>
<td>Integrated health model initiative</td>
<td>2.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Other business operations</td>
<td>2.1</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>105.7</strong></td>
<td><strong>106.8</strong></td>
</tr>
<tr>
<td>Investments</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Strategic focus areas and core operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic focus areas</td>
<td>24.9</td>
<td>21.7</td>
</tr>
<tr>
<td>Advocacy</td>
<td>27.1</td>
<td>25.1</td>
</tr>
<tr>
<td>Health, science and medical education</td>
<td>15.7</td>
<td>14.4</td>
</tr>
<tr>
<td>Communications and marketing</td>
<td>22.1</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>89.8</strong></td>
<td><strong>77.9</strong></td>
</tr>
<tr>
<td>Governance</td>
<td>14.2</td>
<td>13.4</td>
</tr>
<tr>
<td>Administration and operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information technology</td>
<td>28.1</td>
<td>29.5</td>
</tr>
<tr>
<td>Corporate services</td>
<td>5.8</td>
<td>5.6</td>
</tr>
<tr>
<td>Senior executive management</td>
<td>7.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Physician engagement and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portfolio management</td>
<td>14.2</td>
<td>11.2</td>
</tr>
<tr>
<td>General counsel</td>
<td>5.1</td>
<td>5.0</td>
</tr>
<tr>
<td>Finance and risk management</td>
<td>6.7</td>
<td>6.6</td>
</tr>
<tr>
<td>Human resources</td>
<td>5.1</td>
<td>4.7</td>
</tr>
<tr>
<td>Strategic planning and health analytics</td>
<td>2.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Other</td>
<td>18.0</td>
<td>16.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>92.0</strong></td>
<td><strong>86.0</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>315.0</strong></td>
<td><strong>295.8</strong></td>
</tr>
<tr>
<td>Health2047</td>
<td>10.5</td>
<td>6.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>325.5</strong></td>
<td><strong>302.4</strong></td>
</tr>
</tbody>
</table>

### 14. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. For the year ended December 31, 2017, the AMA has evaluated all subsequent events through February 28, 2018, which is the date the consolidated financial statements were available to be issued.
INDEPENDENT AUDITORS’ REPORT

The Board of Trustees of American Medical Association

We have audited the accompanying consolidated financial statements of the American Medical Association (the “AMA”) and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2017 and 2016, and the related consolidated statements of activities and of cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors’ Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor’s judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the AMA’s preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the American Medical Association and subsidiaries as of December 31, 2017 and 2016, and the results of its activities and changes in its equity and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP
Chicago, Illinois
February 28, 2018

Written Statement of Certification of Chief Executive Officer and Chief Financial Officer

The undersigned hereby certify that the information contained in the audited financial statements of the American Medical Association for the years ended December 31, 2017 and 2016 fairly presents, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 28, 2018
2017–2018 OFFICERS AND TRUSTEES
2017–2018 AMA BOARD OF TRUSTEES AND EXECUTIVE LEADERSHIP

Board of Trustees

David O. Barbe, MD, MHA  
*President*

Barbara L. McAneny, MD  
*President-elect*

Andrew W. Gurman, MD  
*Immediate Past President*

Susan R. Bailey, MD  
*Speaker, AMA House of Delegates*

Bruce A. Scott, MD  
*Vice Speaker, AMA House of Delegates*

Gerald E. Harmon, MD  
*Chair*

Jack Resneck Jr., MD  
*Chair-elect*

Patrice A. Harris, MD, MA  
*Immediate Past Chair*

Jesse M. Ehrenfeld, MD, MPH  
*Secretary*

William V. Edwards, MD, MBA  
William E. Kobler, MD

Russell W.H. Kridel, MD  
William A. McDade, MD, PhD

S. Bobby Mukkamala, MD  
Albert J. Osbahr III, MD

Stephen R. Permut, MD, JD  
Ryan J. Ribeira, MD, MPH

Karthik V. Sarma, MS  
Carl A. Sirio, MD

Georgia A. Tuttle, MD  
Kevin W. Williams, MSA

Executive Management

James L. Madara, MD  
*Executive Vice President and Chief Executive Officer*

Standing Committees

**Executive Committee**

Gerald E. Harmon, MD  
*Chair*

Jack Resneck Jr., MD

David O. Barbe, MD, MHA

Barbara L. McAneny, MD

Andrew W. Gurman, MD

Jesse M. Ehrenfeld, MD, MPH

Susan R. Bailey, MD

Patrice A. Harris, MD, MA

**Audit Committee**

William E. Kobler, MD  
*Chair*

William V. Edwards, MD, MBA

Russell W.H. Kridel, MD

Barbara L. McAneny, MD

William A. McDade, MD, PhD

Bruce A. Scott, MD

Georgia A. Tuttle, MD

**Awards & Nominations Committee**

Russell W.H. Kridel, MD  
*Chair*

Willarda V. Edwards, MD, MBA

Jesse M. Ehrenfeld, MD, MPH

S. Bobby Mukkamala, MD

Ryan J. Ribeira, MD, MPH

Karthik V. Sarma, MS

Bruce A. Scott, MD

**Compensation Committee**

Stephen R. Permut, MD, JD  
*Chair*

William E. Kobler, MD

Carl A. Sirio, MD

Georgia A. Tuttle, MD

Gerald E. Harmon, MD  
*(ex-officio w/vote)*

Jack Resneck Jr., MD  
*(ex-officio w/vote)*

Patrice A. Harris, MD, MA  
*(ex-officio w/vote)*

**Finance Committee**

Georgia A. Tuttle, MD  
*Chair*

Susan R. Bailey, MD

William A. McDade, MD, PhD

Albert J. Osbahr III, MD

Stephen R. Permut, MD, JD

Carl A. Sirio, MD

Kevin W. Williams, MSA

Note: Drs. Harmon, Resneck and Harris serve on all committees, except where otherwise noted, as ex-officio members without vote. Dr. Barbe serves on all committees as an ex-officio member with vote.
Subject: AMA 2019 Dues

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee F
(Octa V. Johnson, MD, Chair)

RECOMMENDATION

2019 Membership Year

The Board of Trustees recommends no change to the dues levels for 2019, that the following be adopted and that the remainder of this report be filed:

<table>
<thead>
<tr>
<th>Membership Category</th>
<th>Dues Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Members</td>
<td>$420</td>
</tr>
<tr>
<td>Physicians in Their Second Year of Practice</td>
<td>$315</td>
</tr>
<tr>
<td>Physicians in Military Service</td>
<td>$280</td>
</tr>
<tr>
<td>Physicians in Their First Year of Practice</td>
<td>$210</td>
</tr>
<tr>
<td>Semi-Retired Physicians</td>
<td>$210</td>
</tr>
<tr>
<td>Fully Retired Physicians</td>
<td>$84</td>
</tr>
<tr>
<td>Physicians in Residency Training</td>
<td>$45</td>
</tr>
<tr>
<td>Medical Students</td>
<td>$20</td>
</tr>
</tbody>
</table>

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.
At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy H-140.837, “Anti-Harassment Policy” (see Appendix for full text). The policy was proffered by Board of Trustees Report 23-A-17, which provided that:

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

Board of Trustees Report 23-A-17 also noted that AMA Human Resources policies establish zero tolerance regarding harassment with respect to AMA personnel, agents, and nonemployees, including AMA members. This report of the Board of Trustees recommends procedures to fully implement the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities, such as the RVS Update Committee (RUC) and CPT Editorial Panel.

DISCUSSION

Professional associations’ anti-harassment policies are designed to support the open exchange of ideas central to their mission and to ensure that those who participate in association activities “enjoy an environment free from all forms of discrimination, harassment, and retaliation” [1]. Surprisingly few professional associations have published anti-harassment policies. These associations have established mechanisms to address allegations of harassment that designate the association officer(s) or other association authority to whom incidents should be reported, provide for confidential investigation of alleged inappropriate conduct, and define sanctions that may be imposed if conduct is found to violate association policy [1-5].

The Board notes that the AMA’s existing mandatory recurring anti-harassment training includes not only staff, but also members of the Board and all AMA councils and section governing councils. It is the Board’s hope that this training will educate AMA leaders on what is and is not acceptable behavior, to help ensure the absence of harassing behavior in connection with meetings of AMA entities. However, given our zero tolerance policy for such behavior, we believe that a formal process for reporting, investigation and resolution should be established.
AMA Human Resources Policy 015 provides that a complaint of harassment by an AMA staff
member be reported immediately to the Senior Vice President of Human Resources or the
Executive Vice President for investigation and appropriate action. AMA Human Resources Policy
205 designates an external vendor to confidentially receive concerns regarding failure to comply
with law, regulation or policy. The vendor will notify AMA of any concern received so that AMA
may investigate. HR Policy 205 does not by its terms extend to the House of Delegates, councils,
sections, or all other AMA entities, such as the RUC and CPT Editorial Panel.

The Board believes it is preferable to address allegations of harassment at the time they occur,
whenever possible. In some cases, individuals who are the recipients of or who witness what they
perceive to be harassing conduct may elect to address the conduct with the accused as a first step,
giving the individual an opportunity to apologize and to correct behavior. When the recipient or
witness is uncomfortable addressing harassing behavior directly, or is dissatisfied with the
accused’s response to a direct address, the Board recommends that harassing conduct be reported in
keeping with the policy set out below.

The Board further believes it is the responsibility of those who chair activities associated with the
AMA to assist in enforcing Policy H-140.837, “Anti-Harassment.” For meetings of the AMA
House of Delegates, the Board deems the Speaker and Vice Speaker of the House to be appropriate
authorities to receive complaints of harassment involving AMA House of Delegates. For other
activities associated with the AMA, such as meetings of AMA councils, sections, the RVS Update
Committee (RUC), or CPT Editorial Panel, the Board deems the presiding officer(s) of such
activities to be appropriate authorities to receive complaints. Alternatively, complaints may be
lodged with the Chair of the Board or the AMA Office of General Counsel. Absent an emergent
situation, the recipient of the complaint must maintain the report in confidence, aside from the
further reporting called for by policy. Additionally, and consistent with AMA Human Resources
Policy 205, the Board believes that individuals who are not comfortable with in-person reporting to
the above-designated authorities should have the option of reporting to an outside vendor.

RECOMMENDATION

Consistent with approaches taken in the professional community and in keeping with existing
AMA policy regarding harassment, the Board of Trustees recommends that Policy H-140.837,
“Anti-Harassment Policy,” be amended by deleting Section 2 thereof, in its entirety, that the
following be adopted, and that the remainder of this report be filed:

1. Reporting a complaint of harassment

Any persons who believe they have experienced or witnessed conduct in the AMA House of
Delegates in violation of Anti-Harassment Policy H-140.837 should promptly notify the
Speaker or Vice Speaker of the House or the AMA Office of General Counsel.

Any persons who believe they have experienced or witnessed conduct in other activities
associated with the AMA (such as meetings of AMA councils, sections, the RVS Update
Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837
should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or
either the Chair of the Board or the AMA Office of General Counsel.

Anyone who prefers to register a complaint to an external vendor may do so using an AMA
compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the
reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.

2. Investigations

Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. Disciplinary Action

If AMA Human Resources determines that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, and (ii) refer the matter to a three-member disciplinary committee comprised of the Chair of the Board of Trustees, the Immediate Past President of the AMA and the President-Elect of the AMA, for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities and/or referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action.

If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, the disciplinary committee shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, the disciplinary committee shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality

To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice. (New HOD Policy)

Fiscal note: Less than $1,000
REFERENCES


APPENDIX

AMA Policy H-140.837, “Anti-Harassment Policy”

1. Our AMA adopts the following policy:

**Anti-Harassment Policy Applicable to AMA Entities**

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

**Definition**

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

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.
Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

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

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

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

2. Our AMA's Board of Trustees will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident; and consider and prepare for future consideration by the House of Delegates, potential corrective action and/or discipline for conduct in violation of this policy, with report back at the 2017 Interim Meeting.
Subject: Plan for Continued Progress toward Health Equity (Resolution 601-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

Resolution 601-A-17, “Reinstate the AMA Commission to End Health Care Disparities,” which was introduced by New York, asks “that the American Medical Association reinstate the Commission to Eliminate Health Care Disparities, including goals and objectives that are Specific, Measurable, Agreed Upon, Realistic and Time Related (SMART) metrics.” The AMA Board of Trustees requested, Reference Committee F recommended, and the House of Delegates approved referral of Resolution 601 for “a report back to the House of Delegates with a more comprehensive and sustainable plan for continued progress toward health equity.”

BACKGROUND

In September, the Board Chair, acting on behalf the Board of Trustees, appointed a time-limited Health Equity Task Force with ten members drawn from a number of the AMA constituencies with special interest and expertise in health and health care disparities, diversity and inclusion, and health equity to advise the Board on an action plan.

The members of the Task Force are as follows:

Willarda V. Edwards, MD, MBA; Board of Trustees; Task Force Chair
Frank A. Clark, MD; Minority Affairs Section Chair
Erick A. Eiting, MD, MPH; Advisory Committee on LGBTQ Issues
Ved V. Gossain, MD; International Medical Graduates Section Governing Council
Patrice A. Harris, MD, MA; Board of Trustees
Diana E. Ramos, MD, MPH; Former member, Minority Affairs Section Governing Council
Malcolm D. Reid, MD, MPP; New York Delegation
Katrina L. Rhodes, MD, MS; YPS Assembly Delegate, American Association of Public Health Physicians
Patricia L. Turner, MD; Immediate Past Chair, Council on Medical Education
Siobhan M. Wescott, MD, MPH; Minority Affairs Section Governing Council

The Task Force was asked to adopt a definition of health equity against which proposed actions can be tested; learn from the contributions of the Commission to End Health Care Disparities; build on AMA’s leadership, capabilities, and its advocacy and strategic efforts; and recommend actions and efforts that can be undertaken by AMA to positively contribute to health equity and to communicate its commitment to health equity.

The existence of gaps in health care across segments of the U.S. has been documented in previous AMA reports and in a legion of reports and articles from other credible sources. It is not the
purpose of the Task Force or this report to summarize or replicate that information here. The AMA captures a selection of relevant information and data at https://www.ama-assn.org/delivering-care/reducing-disparities-health-care.

PROCESS

The Health Equity Task Force convened in person to hold facilitated discussions on December 19, 2017, and on February 11, 2018. Task Force members provided input before, between and following meetings, including reviewing interim drafts of this report. In addition, the Task Force had a large number of reports and articles at their disposal throughout the deliberations. Finally, related AMA policy was gathered and included in the Task Force resources.

At in-person meetings, the Task Force reviewed the history, actions, and achievements of the Commission to End Health Care Disparities. The Task Force was inspired by the Commission’s ground work, track record, and the powerful collaborations it established. The Task Force thought it critical to honor the Commission’s legacy and build upon it by taking AMA work on health equity to a new, more embedded and sustainable level and to do so with the expectation that working with other organizations will continue to be an essential component of the AMA’s commitment to health equity.

The Task Force heard a presentation on current AMA work related to health equity and contributed their first-hand knowledge. Task Force members proposed a robust list of past and current tactics the AMA might energize and new ones the AMA might take on. The Task Force then received written input about each of these from staff subject matter experts. This background was considered as the Task Force reviewed and used a priority screen to rate various actions. In addition to the input from staff, a survey of Federation organizations was fielded to gather information about their work on health equity, health disparities, and diversity and inclusion. This information will serve to provide a wider window on potential future tactics and collaborations as the Task Force recommendations are implemented.

RESULTS

Definition

The Task Force reviewed a number of definitions of health equity drawn from the literature and the public records of other organizations, identifying common themes. The Task Force wished to arrive at wording that clearly conveys a guiding perspective for its recommendations and the AMA’s actions going forward. A number of Task Force members penned potential definitions which were then discussed by all. Task Force members uniformly expressed a desire to keep the definition short and simple to facilitate communication to a variety of audiences. Lastly, the definition should be aspirational without caveats reflecting barriers or modifications based on possible differences in health potential.

The consensus definition is the following: “Health Equity is optimal health for all.” This phrase reflects what the AMA is working toward and what it stands for.

It is important to note that this definition refers to all aspects of health, including mental/behavioral health, when referring to health. The Task Force was intentional in that regard so as not to imply that mental/behavioral health is distinct from health in general.
The Task Force expects that often the definition will be followed by explanations of how health equity can be achieved, including discussion of social determinants as key factors influencing health equity.

The Task Force acknowledges that the AMA and physicians cannot control all factors that need to change in order to achieve health equity. For some the AMA’s role will be to identify their importance and to urge those who can have a direct role to act. Most, if not all, determinants of health must be addressed in collaboration with others. Further, individuals themselves must be engaged, but without implying that they bear full responsibility for their health outcomes.

**Populations**

When speaking of disparities in health, the Task Force uses the commonly understood meaning of differences in health outcomes among groups of people. Groups experiencing disparities often lack political, social, or economic power. The Commission to End Health Care Disparities focused on disparities experienced by racial and ethnic minorities. While acknowledging that those disparities have not been sufficiently addressed and should remain a high priority in the AMA work, the Task Force proposes broadening the list of populations of interest to include the many others for which disparities have been documented. The Task Force points out that these identities may have a multiplier effect when they are co-occurring, i.e., when an individual belongs to more than one disadvantaged group.

The composition of the Task Force itself represents the Board’s expectation that the Task Force recommendations will be applied broadly, and is in close alignment with Healthy People 2020 ([https://www.healthypeople.gov/](https://www.healthypeople.gov/)) which points to “many dimensions of disparity,” and lists “race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location” as contributing “to an individual’s ability to achieve good health.”

In considering the list of populations to which the AMA’s work might be applied, the Task Force makes the following points:

1. Populations once thought of as “minority” may soon no longer be the minority in regard to population percentages, but disparities and inequities have endured and will continue.
2. Wording preferences around the labels “sex and sexual identity” have continued to evolve.
3. Though the Task Force is taking an inclusive view of health equity and populations, priorities will have to be set and target populations specified for specific change initiatives. That tension will be ongoing at the programmatic level, and making choices will be difficult.

The AMA will not be able to address all needs immediately. AMA will always have finite resources and will need to make decisions about how best to leverage them.

With those caveats, the Task Force settled on the following list of population descriptors by which populations that experience health disparities may be identified: Race, ethnicity, gender, gender identity, sexual orientation, age, disability, socioeconomic status, geographic location, and educational level. The Task Force points out that the list is not intended to be exhaustive, that is, it does not preclude adding populations for which inequities in health outcomes are documented.

**Strategic Framework**

Having defined the health equity goal for the AMA, the Task Force identified key strategies that constitute how the AMA can work toward realizing the goal of achieving health equity. These are the big themes of work that together make up the AMA’s contribution to achieving the health
equity goal. This strategic framework is intended to provide enduring guideposts for a sustained effort, while appreciating that individual actions or tactics necessarily will change through time. The Task Force proposed the following strategic framework that outlines key AMA roles, and for which tactics can be grouped:

- Advocate for health care access for all;
- Promote equity in care;
- Increase health workforce diversity and cultural awareness/competency;
- Influence determinants of health; and
- Voice and model commitment to health equity.

Several approaches cross these five framework elements. First, the AMA should partner with others. Many organizations and individuals have been working on health equity for a long time. The AMA should not re-invent efforts where they exist and are successful, but should find opportunities for respectful collaboration so that an even greater impact can be achieved. Second, metrics should be specified to describe the outcomes expected from any activity and progress should be tracked and reported. These metrics will establish accountability for results and serve as a guide in adjusting tactics to enhance impact. Third, respect for the patient-physician relationship should be central to the AMA efforts. Engaging with patients and increasing health literacy will be necessary.

Organizational Home for Health Equity

The Task Force concluded overwhelmingly that the AMA must establish a structural or organizational component charged with looking through the health equity lens to facilitate, coordinate, and enhance current streams of work and to stimulate additional work to increase the AMA health equity footprint and impact. This recommendation is offered as the top priority of the Task Force. The characteristics of an organizational home, e.g., a “Center,” should be designed to elevate the importance of and to sustain the AMA’s health equity efforts.

The Task Force suggests such a home for health equity would be expected to have the following features:

- Dedicated resources, including staff and budget; an advisory body; accountability for creating a multi-year roadmap and related programmatic actions such as developing effective partnerships with a variety of stakeholders, creating and curating tools and resources for physicians, and seeking external funding sources, e.g., grants, as appropriate;
- Responsibility for facilitating and coordinating health equity work across focus areas and other organizational units and thereby stimulating and advancing health equity work;
- Authority to propose through the AMA planning process specific additional initiatives and implement those approved; and
- Accountability for developing a dashboard of metrics by which results are tracked, and responsibility for reporting on health equity efforts to the Board and, through the Board, to the HOD.

Communication

The Task Force was charged with advising on how the AMA should communicate its commitment to health equity. The creation of an organizational presence is part of doing so. An ongoing communication plan and additional definitional and explanatory materials should be developed by the health equity staff working with communications staff. It should leverage all AMA
communication vehicles, including special events and AMA leadership speeches, to enable the AMA to “speak with one voice” about the importance of health equity and the AMA’s commitment to action. In the end, achievements will be the foundation for demonstrating true commitment.

Tactics for Consideration

In the course of its work, the Task Force discussed a number of possible activities that might be undertaken as part of an AMA health equity roadmap and screened them by ease of implementation and potential impact.

The Task Force suggests that further vetting of specific tactics to be pursued become the responsibility of the new organizational unit as part of the AMA’s planning process.

Further, the Task Force submits the following as deserving of further consideration by the dedicated health equity entity as it organizes, sets its priorities, and develops a multi-year roadmap:

- Advocate for a variety of incentives for treating currently underserved patients;
- Build upon current Improving Health Outcomes (IHO) and Accelerating Change in Medical Education (ACE) Consortium work on chronic disease prevention and treatment;
- Encourage health equity-promoting solutions through the AMA’s innovation ecosystem;
- Provide grants to support specific kinds of health equity work by others; and
- Review and address as indicated lack of diversity within AMA.

RECOMMENDATIONS

The Board of Trustees recommends the following be adopted in lieu of Resolution 601-A-17 and the remainder of the report be filed:

1. That Health Equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, promoting equity in care, increasing health workforce diversity, influencing determinants of health, and voicing and modeling commitment to health equity. (New HOD Policy)

2. That our AMA develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities. (Directive to Take Action)

3. That the Board provide an annual report to the House of Delegates regarding AMA’s health equity activities and achievements. (Directive to Take Action)

Fiscal note: $1,000,000 annually.
REFERENCE

REPORT OF THE BOARD OF TRUSTEES

B of T Report 34-A-18

Subject: AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies (Resolution 607-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

---------------------------------------------------------------

At the 2017 Annual Meeting, Resolution 607-A-17 was introduced by the American Association of Public Health Physicians and referred. Resolution 607-A-17 asked that: (1) the American Medical Association (AMA), AMA Foundation (Foundation), and any affiliated corporations, work in a timely and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; (2) the AMA, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (3) the AMA support efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policymakers.

BACKGROUND

The AMA, as a science-based organization, has long supported environmental issues and spoken out on climate change, including policy H-135.973, “Stewardship of the Environment,” and H-135-969, “Environmental Health Programs,” that encourage physicians to be spokespersons for environment stewardship among other things; H-135.938, “Global Climate Change and Human Health,” that concurs with the scientific consensus that Earth is undergoing adverse climate change and that anthropogenic contributions are significant and will create conditions affecting public health with disproportionate impacts on vulnerable populations; and finally H-135.923, “AMA Advocacy for Environmental Sustainability and Climate,” outlining AMA’s support of initiatives to promote environmental sustainability and other efforts to halt global climate change. (See Appendix)

The AMA also has policy prohibiting investments in the tobacco industry as part of our broad strategy to oppose tobacco use (H-500.975[5], “AMA Corporate Policies on Tobacco”).

DISCUSSION

Over the past decade, groups concerned about climate change have pressured academic institutions and endowments to divest fossil fuel-related securities. While some have divested, most have decided not to do so. AMA engaged an independent advisor, Mercer Investments, to review the status of fossil fuel divestment for major investment portfolios and to perform a study evaluating the potential impact of implementing Resolution 607-A-17 and making a recommendation from an investment advisor viewpoint.
Mercer is a subsidiary of March & McLennan Companies ($13.2 Billion in revenue), and is a
global leader in providing institutional investment services. It is an independent advisor that has not
been involved with the AMA investment portfolios.

The AMA also received an outside legal opinion from Sidley Austin LLP, AMA’s outside counsel.
Sidley reviewed Resolution 607-A-17 in the context of the governing standard, the Uniform
Prudent Management of Institutional Funds Act (“the Act”) that is incorporated into Illinois law,
the state law that governs the AMA and the Foundation.

Mercer’s analysis included: (1) an overview of fossil fuel divestment among large institutional
investors; (2) back tests over the last 20 years, evaluating the impact of fossil fuel divestment on
both the actual AMA portfolio and market index portfolios with respect to return and risk; and (3)
future return and risk projections utilizing Mercer’s capital market assumptions, comparing a
portfolio with no constraints and a portfolio implementing fossil fuel divestment.

The overwhelming majority of institutions have made a decision not to divest from fossil fuels. Of
the largest 1,000 retirement plans, only 11 have committed to divest fossil fuels in some form. Of
the 100 largest endowment and foundations, six have committed to divest in some form. The most
common focus of those institutions implementing divestment has been limited to divestment of
investments in coal mining companies. Divestment has not gained traction among US pension
funds, due primarily to the fiduciary standard of best interest of plan participants under ERISA.
The US Department of Labor (DOL) has issued an interpretive bulletin stating “fiduciaries may
never subordinate the economic interests of the plan to unrelated objectives, and may not select
investments on the basis of any factor outside the economic interest of the plan except in very
limited circumstances.” The DOL subsequently opined that fiduciaries may pursue such options but
“may not accept lower expected returns or take on greater risks.” While the market has seen some
divestment activity, most institutions have researched divestment and decided not to proceed at this
time.

As noted above, Mercer performed back tests on both the specific AMA portfolios reflecting
holdings as of December 31, 2017, and index data utilizing the MSCI All Country Index, to
quantify the historic impact of a divestment strategy on return, risk, and return for unit of risk. Due
to data limitations, the Mercer analysis covered only market activity over the last twenty years, for
the period ending December 2017. This period was dominated by low interest rates, low inflation
and generally low market volatility. Over this same period, there was a general decline in energy
prices. As such, this period may not be representative of future periods. Mercer’s analysis of this
period suggests that a divestment of fossil fuels from the AMA Reserve Portfolios is unlikely to
result in a material change to return/risk expectations of the current portfolio. In particular, the
analysis suggests that divestment would result in an increase in total risk (roughly 15 basis points),
as would be expected by a more constrained portfolio, and this increase in risk would be partially
offset by an increase of 7 basis points in expected return. While a divested portfolio in the back test
period would have delivered a slightly higher return on a prospective basis, it would do so with
higher risk or volatility resulting in the same return for risk measurement as the current portfolio.

Independent of the Mercer analysis, scenarios in which higher inflation, higher interest rates and
greater market volatility are more prevalent must be considered in evaluating fossil fuel
divestment. Specific to inflationary risk, energy holdings are likely to prove beneficial to the
current portfolio relative to the divested portfolio, as historically rising inflation results in higher
commodity prices, such as energy. Other academic studies, covering longer time frames and more
market cycles, conclude that the estimated cost of fossil fuel divestment is significant. One such
study, by Professor Daniel Fuschel of the University of Chicago, estimates a diversification cost
from divesting energy stocks of approximately .5 percent per year. Another study, by Dr. Bradford
Cornel of Caltech, estimates the mean risk-adjusted shortfall due to divestment at .23 percent per
year. Based on the current size of the AMA’s portfolio and these studies, an investment shortfall of
$1.3 million to $2.9 million per year could be expected. This investment shortfall does not include
other costs of divestment, such as transaction costs associated with selling and buying securities
and the cost of compliance with fossil fuel divestiture goals, both of which are often material but
not estimable at this point. From a judgment perspective, consideration needs to be given to the
tradeoffs of a less diversified portfolio and how relationships may change over time. From an
investment perspective, not implementing a divestment process is consistent with current market
practice and provides investment flexibility, particularly if the markets return to a higher growth,
higher inflation environment.

In response to those who may question whether investments in fossil fuels may result in wasted
capital/stranded assets, professional asset managers uniformly integrate environmental issues into
their investment due diligence and decision-making process. These professional asset managers
weigh valuation against risk and opportunities, including environmental issues. Markets are
efficient and expectations of future states and events are factored into security prices.

Sidley Austin noted that one of the duties imposed by the Act is “An institution shall diversify the
investments of an institutional fund unless the institution reasonably determines that, because of
special circumstances, the purposes of the fund are better served without diversification”. Since
Resolution 607-A-17, if adopted, would potentially rule out a large sector of the economy
dissimilar to the AMA’s policy restriction on investment in tobacco, which is a much smaller
sector, Sidley opined that such a resolution would unduly interfere with the fiduciary obligations
of the AMA Board of Trustees and the Board of Directors of the Foundation to manage the assets
of these organizations in a fiscally prudent manner.” Sidley stated that its belief is that “the related
objectives of (1) managing assets so as to produce a reasonable return without undue risk and (2)
diversification of investments to achieve this result would require managers of the assets of the
AMA and the Foundation at least to have the option of investing in the fossil fuel sector of the
economy. If these managers concluded that investment in fossil fuel companies and related
enterprises was not necessary to achieve a reasonable return with reasonable risk, they would not
have to make such investments. But absolutely to preclude such investments would be to tie the
hands of these managers in a way that would prevent them from carrying out their responsibilities
under the Act.”

The Sidley Austin legal opinion also noted that there is a critical distinction between the current
AMA policy on investments in tobacco companies and the proposed resolution on investment in
fossil fuel companies. Importantly, the tobacco industry is a far less substantial portion of the
economy than the fossil fuel industry and the companies that depend on or serve that industry. The
tobacco sector represents only 1% of the MSCI All World Index, while fossil fuels represent 6% of
the MSCI All World Index. Sidley Austin concluded that with regard to investments in tobacco
stocks, the current AMA policy does not materially prevent AMA asset managers from exercising
the care that an ordinarily prudent person in a like position would exercise. By contrast, ruling out
any investment in fossil fuel companies and in enterprises which depend on or serve those
companies would place a very major constraint on AMA asset managers.

CONCLUSION

Given the results above, with a bias towards maintaining diversification and flexibility, Mercer
recommends against implementing a divestment requirement. Rather, Mercer recommends the
decision concerning exposure to energy sector investments remain with the AMA’s selected
investment managers. As noted above, a broad number of companies across industries are involved in fossil fuels, resulting in divestment from them having a much more significant impact on the diversification of the portfolio. In addition, not implementing a full divestment process is consistent with the approach taken by most major endowments and pension funds in the United States.

Sidley’s opinion concludes that the proposed resolution, if adopted, “would unduly interfere with the fiduciary obligation of the AMA Board of Trustees and the Board of the AMA Foundation to manage the assets of these organizations in a fiscally prudent manner.” The Board believes it should not be handicapped in fulfilling its fiduciary duty.

The Board shares a strong belief in the scientific consensus on global climate change and its threats to public health, especially for vulnerable populations. However, given the number of companies involved in fossil fuels and the Board’s fiduciary obligations outlined in this report, the Board believes it should focus on legislative, regulatory, and other policy efforts as called for in existing House policy to address the threats of climate change.

RECOMMENDATION

Based on the above analysis, the Board of Trustees recommends that Resolution 607-A-17 not be adopted, and the remainder of this report be filed.
Appendix - 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.

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.


**AMA Advocacy for Environmental Sustainability and Climate H-135.923**

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
At the 2017 Annual Meeting, the House of Delegates referred Resolution 609, “Model Hospital Medical Staff Bylaws.” Resolution 609-A-17, which was introduced by the Organized Medical Staff Section, asks the AMA to:

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

2. post this resource on the AMA website, continuously updated and available on demand to medical staffs, medical staff offices, and medical society staff, and widely distributed as an adjunct to the next edition of the AMA Physician’s Guide to Medical Staff Bylaws; and

3. ask the legal counsels of State Medical Societies to outline state specific restrictions of medical staff self-governance so that these may be posted on the AMA-OMSS website for use by all AMA members.

BACKGROUND

The Physician’s Guide to Medical Staff Organization Bylaws (the “Bylaws Guide”) is the AMA’s primary repository of information for physicians on medical staff governance, and one of the only available resources in the country addressing these matters from the physician’s perspective. The Bylaws Guide comprehensively addresses all major elements of medical staff bylaws with substantial discussion of each topic, including links to and citations of selected laws and regulations, accreditation standards, case law, and relevant AMA policy. See the Appendix for a complete list of topics covered in the Bylaws Guide.

For each topic covered, the Bylaws Guide also presents sample bylaws language that has been broadly structured to fulfill Joint Commission and other accreditation requirements and to support AMA policy on self-governance and other relevant medical staff topics. Nevertheless, the Bylaws Guide is not intended to be used as a “model bylaws” document. Rather, medical staff bylaws must be tailored to suit the needs of particular medical staffs, which differ along multiple dimensions, including nuances of state law, varying hospital accreditation organization requirements, and widely diverging hospital and medical staff characteristics. These differences substantially affect not only how individual bylaws provisions must be constructed but also which provisions should be included in the first place.
DISCUSSION

Model medical staff bylaws

Resolution 609-A-17 asks the AMA to create a set of model medical staff bylaws that can account for all of these differences. Unfortunately, there are simply too many permutations to produce a single, coherent set of model bylaws that would be any more useful than the illustrative content already included in the Bylaws Guide. One alternative, which is hinted at by the resolution, might be to develop a comprehensive database of sample bylaws language covering each major conceivable situation. A user might query this database, for example, to obtain appropriate bylaws language on procedures for voting to amend the bylaws for a medical staff that: (a) exists within a multi-hospital system; (b) is not formally unified with the other medical staffs in the system; (c) includes a telemedicine membership category; and (d) is in a hospital accredited by The Joint Commission. Changing any one of these baseline conditions could affect how this voting provision must be written for this particular medical staff; accordingly, the database would have to include many distinct provisions to address all relevant combinations. Multiply this case by the many other similarly complex medical staff governance situations and the massive scope of this project becomes clear. While the task is not impossible, it would be costly to implement (as much as $100,000 upfront) and to maintain ($20,000 or more per year). Furthermore, whatever value a medical staff might find in the existence of such a database would be diminished in part by the fact that the staff would still have to retain legal counsel to ensure that any provisions pulled from the database were appropriately tailored for that hospital’s and medical staff’s unique conditions.

Other ways to augment the AMA’s medical staff resources

Although the creation of a set of model medical staff bylaws may be impractical, there are steps the AMA can take immediately to enhance the value of its medical staff resources. For example, as highlighted by testimony on Resolution 609-A-17, there exists a need for additional information on key state-by-state differences in medical staff bylaws requirements and best practices, especially on emerging issues such as the intersection of employment law and medical staff bylaws. While the Bylaws Guide includes detailed discussion on some state-by-state issues (e.g., the contractual status of medical staff bylaws), the AMA would be well-served to review this resource to ensure that it covers all of the most relevant bylaws topics on which there are significant state-by-state differences.

Additionally, recognizing that the medical societies of many states (including California, Massachusetts, and North Carolina, among others) already maintain excellent state-specific guidance for medical staffs, the AMA should work with the Federation to catalog and make physicians aware of the availability of these valuable state-level resources.

Finally, the AMA should continue its efforts to improve the usability and accessibility of its current and future medical staff-related content, another objective hinted at by Resolution 609-A-17. As presently constituted, the Bylaws Guide is a densely written document presented in a static format. While the core content must by its nature remain somewhat legalistic in order to retain its value, there are a variety of ways to reimagine this content in a more interactive and engaging way—for example, by layering more readily accessible resources atop the underlying content. Such efforts are already underway; specifically, in response to a resolution adopted at the 2017 Annual Meeting, the AMA has developed a 30-minute interactive education module instructing medical staff leaders and other physicians on how to address disruptive physician behavior.ii The module, which offers CME credit, takes as its starting point the “AMA Model Medical Staff Code of Conduct” and ultimately directs learners to that and other resources included in the Bylaws Guide. The AMA
should continue to identify and pursue such opportunities to more effectively engage physicians using its medical staff content.

CONCLUSION

The *Physician’s Guide to Medical Staff Organization Bylaws* is a valuable reference manual for physicians seeking to draft or amend medical staff bylaws and to better understand emerging issues in health care that impact the medical staff. Although comprehensive in scope and including hundreds of sample bylaws provisions, the Bylaws Guide was not developed to serve as a set of model medical staff bylaws. This direction is intentional, owing to the fact that bylaws must be carefully tailored to each medical staff, and that there are simply too many permutations of meaningful differences in state law, accreditation requirements, and hospital and medical staff characteristics to create truly useable model bylaws.

We therefore recommend that our AMA preserve the largely educational and illustrative nature of its medical staff-related content, including the Bylaws Guide, and not pursue the development of a separate set of model medical staff bylaws. Instead, we recommend that the Bylaws Guide be augmented to more fully discuss key bylaws matters that may differ from state to state, and that our AMA work with the Federation to catalog the many valuable state-specific medical staff resources available to physicians. Additionally, we recommend that our AMA continue to pursue opportunities to improve the user experience with our AMA’s medical staff resources.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 609-A-17, and that the remainder of the report be filed:

1. That our AMA continue to update the *Physician’s Guide to Medical Staff Organization Bylaws* to address emerging issues in medical staff affairs, including relevant changes to medical staff regulatory and accreditation requirements, such as those outlined in the Medicare Hospital Conditions of Participation and in the accreditation standards of The Joint Commission and other hospital accrediting organizations. (Directive to Take Action)

2. That our AMA develop guidance for physicians on key state-by-state differences in medical staff bylaws requirements and best practices, and work with state medical societies to catalog state-specific medical staff resources available to physicians. (Directive to Take Action)

3. That our AMA pursue opportunities to improve the accessibility and usability of the content contained in the Physician’s Guide to Medical Staff Organization Bylaws, including but not limited to development of supplemental materials such as education modules, checklists, and so forth. (Directive to Take Action)

Fiscal note: Moderate – between $5,000 and $10,000

Notes:


2 The module is now available through the AMA Education Center: [https://cme.ama-assn.org/Activity/5976608/Detail.aspx](https://cme.ama-assn.org/Activity/5976608/Detail.aspx).
APPENDIX

Table of Contents -- Physician’s Guide to Medical Staff Organization Bylaws

How to Use this Guide

1. Bylaws: The Basics
   1.1 Medical Staff Self-Governance
   1.2 Medical Staff Bylaws as a Contract
   1.3 “Compacts” versus Bylaws
   1.4 Compliance with Accreditation and Regulatory Requirements
   1.5 System Bylaws
   1.6 Medical Staff Unification and Disunification
   1.7 New Bylaws?
   1.8 Joint Commission Standard MS.01.01.01: Improve Bylaws and Promote Self-Governance
      1.8.1 Required Bylaws Content
      1.8.2 Delegation of Authority
      1.8.3 Binding Effects on Signatories
   1.9 Splitting the Bylaws?
   1.10 Improving the Bylaws
   1.11 Independent Medical Staff Counsel

2. Preliminaries
   2.1 Preamble and Statement of Purpose
   2.2 Definitions
      2.2.1 Clinical Privileges
      2.2.2 Day
      2.2.3 In Good Standing
      2.2.4 Investigation
      2.2.5 Physician

3. Membership Qualifications, Rights, and Responsibilities
   3.1 What does Membership Mean?
   3.2 The Right to Practice
   3.3 Basic Qualifications for Membership
   3.4 Eligible Professions
   3.5 Nondiscrimination
   3.6 Participation in Third-Party Arrangements or Other Interests
   3.7 Health Status, Including Aging
   3.8 Criminal/Credit Clearance
   3.9 Geographic Qualifications
   3.10 Economic Credentialing
   3.11 Exclusive Credentialing
   3.12 Professional Liability Insurance
   3.13 Board Certification and Recertification
   3.14 Emergency Department Coverage Responsibility
   3.15 Conduct/Behavior
   3.16 Ethics Standards
   3.17 Committee Service
   3.18 Peer Review Support
   3.19 Compliance Codes
3.20 Exclusion from Medicare
3.21 Employed or Independently Contracted Physicians
3.22 Hospitalists
3.23 Voting Rights
3.24 Payment of Dues and Use of Medical Staff Funds
3.25 Compliance with Hospital Policy
3.26 Leaves of Absence
3.27 Term of Membership

4. Categories of Membership
   4.1 Active Category
   4.2 Consulting Category
   4.3 Courtesy Category
   4.4 Administrative Category
   4.5 Affiliate or Community Category
   4.6 Call Coverage Category
   4.7 Telemedicine Category
   4.8 Temporary Category
   4.9 Changing Categories

5. Application Process for New and Renewed Membership
   5.1 Pre-Application Issues
   5.2 Content of the Application Form
   5.3 Application Procedure
   5.4 Review of Professional Liability History
   5.5 Application Deadlines
   5.6 Expedited Credentialing
   5.7 Drug Testing

6. Clinical Privileges
   6.1 Exclusive Mechanism for Granting Privileges
   6.2 Standards and Criteria for Granting Privileges
   6.3 Admitting Privileges
   6.4 Privileges in More than One Department
   6.5 Right to Exercise Privileges Conferred
   6.6 Temporary Privileges
   6.7 Disaster PRIVILEGES
   6.8 Exclusive Contracts
   6.9 Telemedicine Privileges
   6.10 Core Privileging
   6.11 Histories and Physicals
   6.12 Resigning/Relinquishing/Surrendering Privilege

7. Peer Review
   7.1 Focused and Ongoing Professional Practice Evaluation – “FPPE” and “OPPE”
   7.2 Proctoring
   7.3 External Peer Review
   7.4 Review of Allied Health Professionals
   7.5 Corrective Action
   7.5 No Corrective Action Exemption
   7.6 Initiation of Corrective Action
7.7 Sexual Harassment
7.8 Code of Conduct
7.9 Summary Suspension
7.10 Automatic Suspension

8. Hearings
8.1 Hearing Process
8.2 Actions Resulting in Entitlement to Hearing Rights
8.3 Statutory Standards for Hearings
8.4 Hearing Body
8.5 Hearing Panel with a Hearing Officer
8.6 Hearing Panel Decision
8.7 Allied Health Professional Hearing and Appeal Rights

9. Appeals

10. Reporting Actions to Governmental Agencies

11. Officers and Representatives of the Medical Staff
   11.1 Elections
   11.2 Qualifications
   11.3 Conflicts of Interest
   11.4 Duties of Medical Staff Officers
   11.5 Duties of Medical Staff Representatives
   11.6 Orientation and Training of Officers
   11.7 Compensation of Officers
   11.8 Removal of Officers

12. Departments
   12.1 Department Chair Authority
   12.2 Selection of a Department Chair
   12.3 Department Leadership Orientation and Training
   12.4 Compensation of Department Chairs
   12.5 Department Meetings

13. Committees
   13.1 Budget Committee
   13.2 Bylaws Committee
   13.3 Continuing Medical Education Committee
   13.4 Credentials Committee
   13.5 Hospitalist Advisory Committee
   13.6 Infection Control Committee
   13.7 Joint Conference Committee
   13.8 Medical Executive Committee
   13.9 Peer Review Committee
   13.10 Quality Assurance/Performance Improvement Committee
   13.11 Utilization Review Committee
   13.12 Wellness Committee/Medical Staff Assistance Committee
   13.13 Compensation for Committee Work
14. Meetings
   14.1 Agendas and Minutes
   14.2 Special Meetings
   14.3 Attendance Requirements
   14.4 Voting
   14.5 Executive Session
   14.6 Quorum Requirements

15. Medical Directors, Chief Medical Officers, Vice Presidents for Medical Affairs, and other Medical Staff Administration

16. Release, Immunity, and Indemnification

17. Confidentiality Protections and Obligations
   17.1 Medical Staff Records
   17.2 Member Credentials Files

18. Credentials Disclosure in the Hospital

19. Amendment of Medical Staff Bylaws, Rules and Regulations, and Policies
   19.1 Bylaws Amendment Process
   19.2 Approval of Amendments
   19.3 Rules and Regulations
   19.4 Medical Staff Policy
   19.5 Conflict Management
   19.6 Inconsistency in Governing Documents
   19.7 External Effects on the Medical Staff Bylaws
      19.7.1 Hospital Transactions
      19.7.2 Hospital Bylaws

Appendices
   Appendix A: AMA Principles for Strengthening the Physician-Hospital Relationship
   Appendix B: Medical Staff Unification/Disunification Discussion Guide
   Appendix C: AMA Model Medical Staff Code of Conduct
   Appendix D: AMA Conflict of Interest Guidelines for the Organized Medical Staff
   Appendix E: AMA Principles for Developing a Sustainable and Successful Hospitalist Program
   Appendix F: Medical Staff and Hospital Engagement of Community Physicians
   Appendix G: AMA Guidelines for Hospital Compliance Program Audits and Investigations
   Appendix H: AMA Model Conflict Management Process
Whereas, The AMA House of Delegates (HOD) allows for the creation of Specialty Section Councils composed of member organizations with common medical interests or specialty training (B-9.1); and

Whereas, The AMA HOD currently recognizes thirty-one (31) Specialty Section Councils within the House of Delegates (B-14.0.1); and,

Whereas, LGBTQ Health has become a fully acknowledged subspecialty of medical practice, spanning a range of medical specialties including, but not limited to, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, endocrinology, plastic surgery; and

Whereas, The study and practice of LGBTQ Health as a recognized subspecialty is vital due to the presence of well-established medical disparities that affect this population; and

Whereas, The AMA Foundation, recognizing the importance of LGBTQ specific medical training, has chosen to utilize the LGBT Honor Fund to establish the creation of subspecialty fellowship training programs in LGBTQ Health; therefore be it

RESOLVED, That our American Medical Association House of Delegates establish a Specialty Section Council on LGBTQ Health. (Directive to Take Action)

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

Received: 03/08/18
RELEVANT AMA POLICY

B-9.1 Purpose.
9.1.1 Specialty Section Councils shall be established by the House of Delegates. Specialty Section Councils shall provide for deliberation and study of scientific educational and other appropriate interests and concerns of the specialty disciplines and the specialty societies representing these disciplines within the AMA.
9.1.2 The Section Council shall, on request, submit to the Board of Trustees nominations for AMA representatives to serve on approved Specialty Certifying Boards.

B-9.2 Composition.
9.2.1 National medical specialty societies represented in the House of Delegates may appoint representatives to the Specialty Section Councils for the medical specialty in which the specialty society participates. Such representatives must be members of the AMA.
9.2.2 Upon recommendation of the Specialty Section Council and approval of the Board of Trustees, national medical specialty societies that are not represented in the House of Delegates may appoint representatives to the Specialty Section Council for the medical specialty in which the specialty society participates. Such representatives must be members of the AMA.

B-9.3 Specialty Society Delegate.
The AMA delegate(s) and alternate delegate(s) from each national medical specialty society represented in the House of Delegates shall also serve in the Specialty Section Council of their respective specialty.

B-9.4 Chair and Vice Chair.
Each Specialty Section Council shall elect a Chair and Vice Chair from within its membership.

Glossary of Terms. B-14.0.1
Section Council - Specialty Section Councils have been recognized by the House of Delegates for the following specialties: Allergy; Anesthesiology; Cardiovascular Disease; Clinical Pharmacology and Therapeutics; Dermatology; Digestive Diseases; Disease of the Chest; Emergency Medicine; Endocrinology; Family and General Practice; Federal and Military Medicine; General Surgery; Genetics; Internal Medicine; Neurological Surgery; Neurology; Nuclear Medicine; Obstetrics and Gynecology; Ophthalmology; Orthopedic Surgery; Otolaryngology-Head and Neck Surgery; Pain and Palliative Medicine; Pathology; Pediatrics; Physical Medicine and Rehabilitation; Plastic, Reconstructive and Maxillofacial Surgery; Preventive Medicine; Psychiatry; Radiology; and Urology.
Whereas, The Resident and Fellow Section (RFS) passed policy 291.001R\(^1\) at the RFS 2015 Annual Meeting asking the RFS to “evaluate entering into arrangements with companies which promote health and fitness that are willing to provide discounts to AMA-RFS members”; and

Whereas, There are a variety of health and fitness companies, including fitness gyms, companies that encourage exercise, weight loss programs, and nutrition companies; and

Whereas, A discount to health and fitness companies would encourage residents and fellows to join the AMA, add additional benefits to our existing members, and would support the AMA’s overall goal of promoting health and wellness\(^2\) among resident and fellow members; and

Whereas, The AMA should be a part of wellness initiatives that impact physician health, including proper exercise, diet and mental health; and

Whereas, Many of the current member discounts (such as insurance companies, car rentals, etc.) do not appeal to most residents and fellows at this stage in their career; and

Whereas, A fitness discount has universal appeal among residents and fellows of different ages and stages of life; and

Whereas, The AMA should consider establishing relationships with health and fitness companies that are available nationwide so that all AMA members are able to benefit from the AMA member discount; and

Whereas, The discount negotiated on behalf of members should be equivalent to or better than the discounts the company offers via other advertisements; therefore be it

RESOLVED, That our American Medical Association promote health and wellness among AMA members (New HOD Policy); and be it further

RESOLVED, That our AMA further investigate and explore relationships with health and fitness companies to promote health and wellness among AMA members, including arrangements under which attractive discounts are offered to AMA members. (Directive to Take Action)

\(^1\) 291.001R Improving Physician Well-Being by Exploring Partnerships with Companies that Promote Health and Fitness: That our AMA-RFS evaluate entering into arrangements with companies which promote health and fitness that are willing to provide discounts to AMA-RFS members. (Resolution 4, A-15)

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

Received: 03/28/18

RELEVANT AMA POLICY

Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles H-405.959
Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles Our AMA will: (1) establish a program that recognizes physicians and physicians-in-training who model wellness and healthy lifestyles in their practice and communities or establish programs that contribute to the wellness of their patients and/or community; and (2) will aid in the development of a health and wellness component in conjunction with the Doctors Back to School Program. Res. 8, A-13

Educating Physicians About Physician Health Programs D-405.990
1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training. Res. 402, A-09 Modified: CSAPH Rep. 2, A-11 Reaffirmed in lieu of Res. 412, A-12, Appended: BOT action in response to referred for decision Res. 403, A-12

Physician Health Programs H-405.961
Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness. CSAPH Rep. 2, A-11 Reaffirmed in lieu of Res. 412, A-12 Reaffirmed: BOT action in response to referred for decision Res. 403, A-12
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-18)

Introduced by: Medical Student Section

Subject: Eliminating Food Waste Through Recovery

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

Whereas, Food rescue is described as the “practice of diverting edible food that would have been thrown out and redistributing this to those in need”;¹,² and

Whereas, Large corporations including Google© participate in programs that donate leftover food;³ and

Whereas, Achieving a 20% reduction in annual edible food waste translates into an additional 30 billion pounds of edible food per year available for human consumption;⁴ and

Whereas, AMA policies H-135.938 and H-135.939 demonstrate the AMA’s support for community programs aimed at furthering sustainable means of waste reduction and for healthcare professionals to partner with community members in realizing similar initiatives; and

Whereas, Achieving a 20% reduction in annual edible food waste translates into an additional 30 billion pounds of edible food per year available for human consumption;⁴ and

Whereas, A recent study estimated food waste annually accounts for more than 25% of total freshwater and 300 million barrels of oil consumed;⁵ and

Whereas, Food rescue is described as the “practice of diverting edible food that would have been thrown out and redistributing this to those in need or those who are food insecure”;⁶ and

Whereas, Charitable organizations often rely on partnerships with farmers, food enterprises, and other entities to rescue food, combat hunger, and alleviate food insecurity;⁷ and

---

³ (trying to find better source but not having too much luck) https://www.huffingtonpost.com/entry/google-airbnb-other-tech-giants-waste-tons-of-food-this-group-rescues-it_us_5773ecbbe4b0eb99355d6027
Whereas, While the EPA’s Food Recovery Hierarchy prioritizes utilizing food rescue to feed the hungry, the total amount of edible food currently rescued is still less than 2%;\(^4,7\) and

Whereas, AMA policies H-135.938 and H-135.939 showcase the AMA’s support for community programs aimed at furthering sustainable means of waste reduction and for healthcare professionals to partner with community members in realizing similar initiatives; therefore be it RESOLVED, That our American Medical Association prioritize sustainability and mitigation of food waste in vendor and venue selection (New HOD Policy); and be it further

RESOLVED, That our AMA encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donation. (New HOD Policy)

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

Date Received: 04/26/18

RELEVANT AMA POLICY

**AMA Advocacy for Environmental Sustainability and Climate H-135.923**
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. (Res. 924, I-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 policy making 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.
(CSAPH Rep. 3, I-08), (Reaffirmation A-14)

See also:
Green Initiatives and the Health Care Community H-135.939
Update on the Food and Drug Administration’s Efforts to Improve Food Safety H-150.940
Sustainable Food D-150.978

---

Whereas, One of the duties of AMA Delegates is to advocate for increased AMA membership
for physicians across the federation; and

Whereas, Our AMA House of Delegates is comprised of delegates representing state and
national medical specialty societies, as well as special sections; and

Whereas, The apportionment of state medical society delegates during the current year is
based on an annual census of the number of AMA members who reside in the state as
determined by a count on December 31 of the previous year; and

Whereas, In the current system of accounting, physicians who join the AMA during the latter
part of a year are incentivized to claim their membership beginning January 1 of the following
year, instead of the latter part of year in which they actually joined (which would cost more
money); and

Whereas, When new members are counted as AMA members for the matter of AMA delegation
apportionments at the beginning of a new year, they are not counted for delegation entitlements
until the following year even though they are AMA members all year long; and

Whereas, Many state medical and national medical specialty societies convene their annual and
other sessions during the latter part of the year; and

Whereas, Updating the methodology for increasing AMA representation at the HOD might result
in more vigorous AMA membership campaigns during the latter part of the year at state medical
and national specialty society events; and

Whereas, The AMA Membership Department has indicated it would not be an undue burden to
produce a second census of the number, specialty and location of AMA members during the
first two weeks of a new year; and

Whereas, To add a second period of time to determine AMA delegation entitlements will require
an amendment to the AMA Bylaws; therefore be it

RESOLVED, That our American Medical Association continue to provide a count of AMA
members for AMA delegation entitlements to the House of Delegates as of December 31 and
also provide a second count of AMA members within the first two weeks of the new year and
that the higher of the two counts will be used for state and national specialty society delegation
entitlements during the current year (Directive to Take Action); and be it further
RESOLVED, That the Council on Constitution and Bylaws prepare appropriate language to add a second period of time to determine AMA delegation entitlements to be considered by the AMA House at its earliest opportunity. (Modify Bylaws)

Fiscal Note: Not yet determined

Received: 04/25/18
Reference Committee G

BOT Report(s)
31  Physician Burnout and Wellness Challenges, Physician and Physician Assistant Safety Net, Identification and Reduction of Physician Demoralization
37  Eliminate the Requirement of H&P Update
39  Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models

CMS Report(s)
04  Health Plans' Medical Advice
05  Financing of Long-Term Services and Supports
06  Integrating Precision Medicine into Alternative Payment Models

Resolution(s)
701  Employed Physicians Bill of Rights
702  Basic Practice Professional Standards of Physician Employment
703  Economic Credentialing
704  Non-Payment and Audit Takebacks by CMS
705  Modify the Clinical Laboratory Improvement Amendment of 1988
706  Ensuring Medicare Coverage for Long Term Care
707  Health Plan Payment of Patient Cost-Sharing
708  Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission
709  Prior Authorization for Durable Medical Equipment
710  Code Status Through the Continuum of Care
711  Compensation for Pre-Authorization Requests
REPORT OF THE BOARD OF TRUSTEES

B of T Report 31-A-18

Subject: Physician Burnout and Wellness Challenges, Physician and Physician Assistant Safety Net, Identification and Reduction of Physician Demoralization (Resolution 601-I-17; Resolution 604-I-17; Resolution 605-I-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

INTRODUCTION

At the 2017 Interim Meeting, three resolutions (601-I-17, “Physician Burnout and Wellness Challenges,” 604-I-17, “Physician and Physician Assistant Safety Net,” and 605-I-17, “Identification and Reduction of Physician Demoralization”) with shared components of a central issue were referred for report back together at the 2018 Annual Meeting. This report addresses the overarching topic and each resolution as it relates to the issue, and presents recommendations accordingly.

Resolution 601-I-17, “Physician Burnout and Wellness Challenges,” was introduced by the International Medical Graduates Section and the American Association of Physicians of Indian Origin. Resolution 601-I-17 asks the American Medical Association (AMA) to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness.

Resolution 604-I-17, “Physician and Physician Assistant Safety Net,” was introduced by the Oregon Medical Association and asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians. Resolution 604-I-17 also directs the AMA to advocate that funding for such safety net programs be sought from such entities as foundations, hospital systems, medical clinics, and donations from physicians and physician assistants.

Resolution 605-I-17, “Identification and Reduction of Physician Demoralization,” was introduced by the Organized Medical Staff Section and asks that the AMA: (1) recognize that physician demoralization, defined as a consequence of externally imposed occupational stresses, including but not limited to electronic health record (EHR)-related and administrative burdens imposed by health systems or by regulatory agencies, is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness.
BACKGROUND

Today’s physicians are experiencing burnout at increasing rates, expressing feelings of professional demoralization, professionally under-valued and overburdened by an ever-changing health care system.1-3 Over 54 percent of practicing physicians report experiencing at least one symptom of burnout, a near 10 percent increase in three years.4 Practicing physicians are not alone in reported symptoms of burnout; resident and medical student burnout is also on the rise. It is recognized that with growing numbers of physicians, residents and medical students experiencing burnout, health care costs will continue to rise and patient safety will suffer.5 Stress, depression and burnout can lead to suicidal ideation and sometimes suicide. While no resolute number has been verified, it is estimated and often cited that 300 to 400 physicians per year die by suicide6, and physician suicide rates are historically higher than the general population.7 Resources such as safety nets and hotlines exist for individuals experiencing suicidal ideation and are available from a number of national and reputable sources.

AMA POLICY

Our AMA recognizes the importance of addressing and supporting physician satisfaction as well as the impact physician burnout may have on patient safety, health outcomes and overall costs of health care. This commitment to physician satisfaction and well-being is evidenced by AMA’s ongoing development of targeted policies and tools to help physicians, residents and medical students, and its recognition of professional satisfaction and practice sustainability as one of its three strategic pillars.

The AMA supports programs to assist physicians in early identification and management of stress. The programs supported by the AMA concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians’ professional and personal lives, as well as when to seek professional assistance for stress-related difficulties (Policy H-405.957, “Programs on Managing Physician Stress and Burnout”). AMA policy and the Code of Ethics acknowledge that when physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided (Code of Ethics 9.3.1, “Physician Health & Wellness”). Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness (Policy H-405.961, “Physician Health Programs”). Educating physicians about physician health programs is greatly important to the AMA. The AMA will continue to work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members about the availability of and services provided by state physician health programs to ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory. Our AMA will continue to collaborate with other relevant organizations on activities that address physician health and wellness. Our AMA, in collaboration with the FSPHP, develops state legislative guidelines to address the design and implementation of physician health programs, as well as messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training (Policy D-405.990, “Educating Physicians About Physician Health Programs”).

The AMA recognizes physical or mental health conditions that interfere with a physician’s ability to engage safely in professional activities can put patients at risk, compromise professional relationships and undermine trust in medicine. While protecting patients’ well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care (Code of Ethics 9.3.2, “Physician Responsibilities to Impaired Colleagues”).
AMA policy defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities. The AMA in the same policy encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians and to develop case finding mechanisms for all types of physicians (Policy H-95.955, “Physician Impairment”). Access to confidential health services for medical students and physicians is encouraged by the AMA to provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services. Our AMA will continue to urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, only focus on current impairment by mental illness or addiction, and to accept “safe haven” non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: (a) be available to all medical students on an opt-out basis; (b) ensure anonymity, confidentiality, and protection from administrative action; (c) provide proactive intervention for identified at-risk students by mental health and addiction professionals; and (d) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and, (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education (Policy H-295.858, “Access to Confidential Health Services for Medical Students and Physicians”).

The AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem not only with practicing physicians, but among residents, fellows, and medical students. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets. In addition, our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. The AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community. Finally, our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements (Policy D-310.968, “Physician and Medical Student Burnout”).

DISCUSSION

Our AMA is committed to upholding the tenets of the Quadruple Aim: Better Patient Experience, Better Population Health, Lower Overall Costs of Health Care, and Improved Professional
Satisfaction. This is evidenced by AMA policy supporting the “Triple Aim” and requesting that it be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers (Policy H-405.955, “Support for the Quadruple Aim”). In order to achieve the fourth aim, the AMA acknowledges that interventions at both system and individual levels are necessary for enhancing physician satisfaction and reducing burnout. The work carried out through the AMA’s Professional Satisfaction and Practice Sustainability strategic focus area is dedicated to this objective.

Resolution 601-I-17 asks the AMA to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness. The AMA has been actively and directly engaged with health care organizations, including state and county medical societies, to build awareness and support for addressing physician burnout. The AMA partnered with the RAND Corporation in 2013 to identify and study the factors that influence physician professional satisfaction, as well as understand the implications of these factors for patient care, health systems, and health policy. This seminal work informed subsequent initiatives and a long-term strategy for AMA’s Professional Satisfaction and Practice Sustainability unit. Key accomplishments and offerings have been realized through launching the free, online, STEPS Forward™ practice transformation platform. This online resource offers over 50 modules of content developed by subject matter experts and is specifically designed for physicians, practices, and health systems. The STEPS Forward platform has been openly shared with leadership of many state and specialty societies, as well as presented to their membership in various forums. In addition, the AMA has partnered with health systems, large practices, state medical societies, state hospital associations and graduate medical education programs to deploy and assess physician burnout utilizing the Mini-Z Burnout Assessment. The assessment offers organizations a validated instrument that provides an organizational score for burnout, along with two subscale measures for “Supportive Work Environment” and “Work Pace and EMR Frustration.” In addition to the organizational dashboard, the assessment is able to provide a comprehensive data analysis complete with medical specialty and clinic level benchmarking. The trends and findings from the assessment are shared and targeted interventions are recommended to the surveying organization. The interventions and suggested solutions are curated from existing STEPS Forward content and through specific best practices identified through AMA collaborators.

Resolution 604-I-17 asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Testimony heard in the reference committee hearing further clarified the request for a task force to research, collect, publish and administer a repository of information about programs and strategies that optimize physician wellness. The AMA, through its ongoing work in the Professional Satisfaction and Practice Sustainability strategy unit, acknowledges the importance of addressing and supporting physician mental health and has developed and published resources to help physicians manage stress and prevent and reduce burnout. The AMA supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians’ professional and personal lives, and when to seek professional assistance for stress-related difficulties.

In addition, our AMA will review relevant modules of the STEPS Forward program and also identify validated student-focused, high-quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these...
resources to medical students. The STEPS Forward platform currently provides relevant modules to address physician well-being, specifically the modules “Preventing Physician Distress and Suicide,” “Improving Physician Resiliency” and “Physician Wellness: Preventing Resident and Fellow Burnout.” In conjunction with STEPS Forward modules, the Mini-Z Burnout Assessments provide participating organizations the option to embed the PHQ-2 Depression Screening Tool. This allows organizations to gain a deeper understanding of those physicians experiencing more severe levels of depression and disinterest and correlate those responses to burnout. The survey also offers a free text section for physicians in need of services to self-identify and receive direct outreach and support. Additionally, the Mini-Z tool provides information on the National Suicide Prevention Lifeline for organizations to utilize in their physician wellness and burnout efforts.

It is demonstrated through current efforts and strategic priorities that the AMA recognizes the importance of assessment and attention to depression in physicians, residents and medical students, as well as the relationship that depression can have with suicidal ideation. Current AMA research and strategic initiatives are focused on enhancing workflows within the system and clinical setting with the intent to scale efficiency and reduce feelings of burnout amongst physicians. The AMA’s role in sharing burnout and depression screening data is to assist physician employers in understanding individual physician burnout and connecting physicians with employee assistance resources. Considering the AMA’s current efforts and ongoing commitment to providing resources on the topics of burnout, distress and suicide prevention, stress reduction, and wellness, convening an exclusive task force separate from the AMA staff already dedicated to this work would be duplicative. While an online search indicates there is no current, easily identifiable suicide prevention line exclusively for physicians or health care workers, there are hotlines available that are open to all individuals regardless of profession. Studying these hotlines as described in the resolution would be resource intensive and the results of such study may not prove applicable to the AMA’s primary audiences; however, making existing relevant AMA resources available to physicians seeking help can be accomplished, and is part of current AMA practices. The AMA will continue to direct physicians to our current resources to learn about strategies, programs and tools related to this topic, and will further explore options for providing more direct assistance for physicians in need.

Resolution 605-I-17 asks the AMA to (1) recognize that physician demoralization is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness. Testimony in the reference committee hearing recognized that “burnout” is a commonly used term favored by many physicians, and while there is some preference for the use of another term instead of “burnout,” there was no consensus on what that term should be. Our AMA recognizes that burnout is characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness. These feelings can manifest as a result from a multitude of driving factors, such as administrative burden, excessive EHR documentation and systemic cultural deficiencies leading to demoralization of physicians. The term “burnout” is often used to encompass the multiple driving factors of physician dissatisfaction as well as the resultant feelings and behaviors associated with being overworked, excessively scrutinized and overburdened with unnecessary tasks. As the term “burnout” is used broadly, this allows for many variations in the interpretation of its meaning. Our AMA does not define the term “burnout” as an individual “resilience deficiency” or character flaw. Our AMA supports and voices a position that burnout is derived from system and environmental issues, not from the individual physician. This position is evidenced by AMA resources and services targeted at system-level approaches to intervention.
In addition, the AMA will continue to advocate for organizations to confidentially survey physicians to understand local levels of burnout and opportunities for strategic improvement. It should be noted that the AMA’s Mini-Z Burnout Assessment is deployed confidentially and takes protective safeguards very seriously to ensure accurate and safe reporting of results. Through leveraging ongoing AMA media channels, hosting educational webinars, live speaking engagements, and the Transforming Clinical Practices Initiative (TCPI) grant through the Centers for Medicare and Medicaid Services (CMS), the AMA is striving to scale awareness and intervention to advance physician satisfaction and help address the burnout epidemic.

CONCLUSION

The AMA is committed to enhancing joy in practice for physicians, residents and medical students. Our AMA will continue its focus on research, advocacy and activation to address the issues presented in each of the resolutions discussed herein. The AMA will continue to work diligently to address the issues through our existing work, partnerships, resource development and policies. We present the following recommendation to not only emphasize the work already being done, but also to further address the issues brought forth in these three resolutions.

RECOMMENDATION

The AMA Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 601-I-17, 604-I-17 and 605-I-17, and that the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
   a. H-405.957, “Programs on Managing Physician Stress and Burnout;”
   b. H-405.961, “Physician Health Programs;”
   c. D-405.990, “Educating Physicians About Physician Health Programs;”
   d. H-95.955, “Physician Impairment;” and
   e. H-295.858, “Access to Confidential Health Services for Medical Students and Physicians.”
   (Reaffirm HOD Policy)

2. That our AMA amend existing Policy D-310.968, “Physician and Medical Student Burnout,” to add the following directives (Modify Current HOD Policy):
   1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
   2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
   3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
   4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

7. Our AMA will encourage hospitals to confidentially survey physicians to identify factors that may lead to physician demoralization.

8. Our AMA will continue to develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (2) develop and promote mechanisms by which organizations and physicians can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being at the system level.

Fiscal note: Minimal – less than $1,000
REFERENCES


INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Board of Trustees (BOT) Report 18-A-17, “Eliminate the Requirement of H&P Update,” was referred for report back at the 2018 Annual Meeting. BOT Report 18-A-17 concerned Resolution 710-A-16, “Eliminate the Requirement of H&P Update,” which was referred during the 2016 Annual Meeting. Resolution 710-A-16, sponsored by Ohio Delegation, asked our American Medical Association (AMA) to work to change the Centers for Medicare & Medicaid Services’ (CMS) Medicare Conditions of Participation (COP) regulations governing the medical history and physician examination update and documentation requirements (H&P update) prior to surgery or a procedure as follows:

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

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

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

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

At the 2016 Annual Meeting, the HOD supported referral of Resolution 710-A-16 because testimony was mixed and the topic involved clinical, legal, and regulatory considerations. The sponsoring delegation testified that physicians should not have to document “no change” in the patient’s H&P update on the day of a procedure or surgery. Other testimony emphasized the importance of documenting updates on the date of surgery and potential risks associated with not documenting changes or “no change” in the patient’s condition. One speaker noted that H&P update requirements are not particularly burdensome to physicians. Additional speakers noted the complexity of the issues brought up by Resolution 710-A-16, and that patient needs may differ depending on their health and the procedures they are receiving.

BOT Report 18-A-17 recommended that Resolution 710-A-16 be adopted and noted that:
The H&P update requirement constitutes a compliance burden for physicians when a patient’s health status remains unchanged without a direct clinical benefit. It is reasonable to create a regulatory presumption that the H&P update was performed and remained unchanged if documentation to the contrary is not provided. Qualified individuals with privileges would still have to document when changes have occurred, thereby, safeguarding patient safety and ensuring a basic standard of care is met.

At the 2017 Annual Meeting, the HOD supported referral of BOT Report 18-A-17 because testimony was mixed—but mostly negative. While there was some support for the report’s recommendations, a preponderance of the testimony expressed concerns about adopting Resolution 710-A-16. Testimony emphasized the importance of documenting the H&P updates on the day of a procedure or surgery and the potential risks associated with not documenting these encounters. A speaker noted that failing to document the H&P update would be a violation of conventional risk management practices. Others questioned whether the documentation is in fact an H&P update. The importance of pre-operative visits was also emphasized, and it was noted that patients can change their minds about surgeries at the last minute. Because a preponderance of the testimony was in opposition to the report’s recommendation, the Reference Committee believed clarification was needed and recommended that it be referred for decision at the 2018 Annual Meeting.

AMA POLICY

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

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

DISCUSSION

Although H&P update requirements constitute a small administrative burden for physicians when a patient’s health status remains unchanged, it is good medical practice and risk management. Also, the current regulatory requirement was issued as an alternative to a more onerous proposed Medicare requirement that would have hindered patient access to care. (See discussion below.) Furthermore, if there is a poor patient outcome, the H&P update provides compelling evidence that an H&P update (even if there is no change in status) was performed and demonstrates compliance with Medicare COP during an investigation.

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

In 2006, CMS issued a final rule, titled: The Medicare and Medicaid Programs: Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations. The final rule incorporated requested changes that reduced compliance burdens on patients and physicians.

Among other things, the final rule expanded the timeframe for completion of the pre-operative H&P to 30 days and expanded the number of permissible professional categories of individuals who may perform the history and physical examination. The final rule also required that all orders, including verbal orders, be dated, timed, and authenticated by a practitioner responsible for the care of the patient. The proposed rule would have required the pre-operative H&P to be completed only by a physician credentialed by the medical staff at the admitting hospital. For many patients, this would have excluded their primary care provider, who may not be credentialed and privileged at the admitting hospital. CMS struck this requirement and put an alternative requirement in place as outlined below:

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

CONCLUSION

The H&P update documentation requirements are utilized to ensure that the physician performing the procedure or surgery attests that the H&P was performed properly, is accurate and up-to-date, and that the patient is deemed to be safe for the planned surgery or procedure. Seeking to reverse this regulatory concession would invite a return to the original proposed rule that the pre-operative H&P must be performed by a physician credentialed and privileged in the admitting hospital. In addition, physicians would no longer have the legal benefit that extends to physicians who are able to demonstrate through documentation that they complied with Medicare COP and accepted standards of care.

RECOMMENDATION

The Board of Trustees recommends that Resolution 710-A-16 not be adopted and the remainder of the report be filed.

Fiscal Note: None.
INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates, Resolution 711-A-17, “Expanding Access to Screening Tools for Social Determinants of Health,” was referred for report back. Resolution 711-A-17, which was introduced by the Medical Student Section, asks that the “AMA provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings.” At the 2017 Interim Meeting of the House of Delegates, Resolution 816, “Social Determinants in Health in Payment Models,” was referred. Resolution 816-I-17, which was introduced by the American College of Preventive Medicine, asks that the “AMA support payment reform policy proposals that incentivize screening for social determinants of health, as defined by Healthy People 2020, and referral to community support systems.”

Resolution 711-A-17 was referred for report back at the 2018 Annual Meeting and Resolution 816-I-17 was referred for report back at the 2018 Interim Meeting. As the referred resolves in each resolution deal with components of a common issue, this report will address the topic as a whole, and present recommendations accordingly.

BACKGROUND

Defining Social Determinants of Health

The World Health Organization defines social determinants of health (SDH) as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.” There is a national emphasis in the United States on addressing the SDH by creating “social and physical environments that promote good health for all.” There are five key areas of SDH: economic stability; education; social and community context; health and health care; and neighborhood and built environment. Within each of these areas, there are key issues that contribute to the underlying factors of SDH. For example, economic stability examines the impact of employment, food insecurity, housing instability and poverty on a patient’s ability to access health care and adhere to treatment.
Recognition of the role SDH play in influencing health outcomes is growing in the health care field, and many physicians are developing strategies to effectively address these conditions which impact every patient. Care models are currently being refined to include selection and implementation of SDH assessment tools; collection of patient-level information related to SDH; creation of workflows to track and address patient needs; and identification of community-based social service resources and tracking referrals.

Evidence-based Screening Tools for Evaluating and Assessing Social Determinants of Health

There presently are several tools available for screening of risks or issues related to SDH. Most tools, including those described here, are free to use. The Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE) Implementation and Action Toolkit, sponsored by the National Association of Community Health Centers, was designed to create and implement a national standardized patient risk assessment protocol to assess and address patients’ SDH as well as tools to respond to SDH data. The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. The full question set can be administered in nine minutes or less. A recent study in the *Journal of the American Board of Family Medicine* found that standardizing SDH data collection and presentation in electronic health records (EHRs) could lead to improved patient and population health outcomes in community health centers and other care settings. As of July 26, 2016, the National Association for Community Health Centers reported that only 4 EHR vendors (EPIC, NEXT GEN, eClinical Works, and GE Centricity) currently support the PRAPARE electronic templates.

Another tool, the Patient Centered Assessment Method (PCAM), assesses a patient’s lifestyle behaviors, mental well-being, social environment, health literacy, and communication and care coordination needs. This resource contains a section focused on actions that can be taken to address the needs and issues identified in the assessment as well as the level of service coordination needed to ensure referrals can be practically accessed by the patient. A 2015 study found that while PCAM did not impact patient satisfaction or perception of practitioners’ empathy, it did increase both the number of onward referrals per referred patient and the proportion of referrals to non-medical services addressing psychological, social, and lifestyle needs.

The American Academy of Family Physicians (AAFP) released an initial screening toolkit for SDH in 2018 to help physicians recognize and respond to various social factors that affect their patients’ health. The toolkit includes both a short and long screening tool that includes questions that have been tested, validated, and purposefully assembled to reveal the health hurdles that patients are facing and a sample patient action plan for staff to indicate what types of referrals are needed for patients. As of the time of this report, there are no studies available on the effectiveness of this toolkit. The aforementioned resources indicate there are evidence-based tools to screen for SDH which are accessible and free for physicians to use.

OCHIN, a nonprofit health information and innovation network, integrated SDH screening tools into leading electronic health records (and released an evidence-based set of SDH domain areas for inclusion in EHRs, which was piloted among EPIC users). The integration of the SDH screening tools into the EHR among EPIC user has the potential to reach 25.8 percent of the U.S. physician practice market share. The SDH flowsheet developed by OCHIN provides several means for easily entering patient-reported SDH information that is not already collected in other places in the EHR, such as demographics or social history. Additionally, the data collection tools were designed to be flexible so that anyone on the care team could enter data.
In addition, in 2017 our AMA in collaboration with Lucro launched a platform that streamlines the ability for physicians and health systems to find a number of tools/solutions available on the market, including screening tools for SDH. The platform allows physicians to request information on the clinical validation for a tool, how the tool fits into a workflow/integrates with an EHR, etc., and compares tools to other options available. The Lucro platform is available at app.lucro.com. Also, AMA is currently developing a STEPS Forward™ module to address SDH which will provide physicians with tools, curriculum, and templates to assist in measuring and addressing SDH. The module will also provide strategies for intervention and resources to assist in the understanding of SDH and implementation of tools in practice. Our AMA expects to release this new module in May 2018.

Incentives for Use of Evidence-Based Social Determinants of Health Screening Tools and Interventions in Clinical Settings

Public payers, such as Medicaid and Medicare, may provide financial incentives to encourage providers to address the social needs of their patients as well as the social conditions in the communities in which they serve. For example, Medicare’s Comprehensive Primary Care Plus (CPC+) model, which is a multi-payer, patient-centered primary care medical home, requires participating clinicians to risk-stratify patients based on health-related social needs and other factors. CPC+ provides extra payments to participating practices to cover non-face-to-face services and allows practices to provide intensive care management and other supportive services to patients with complex needs. According to the 2016 Kaiser Family Foundation 50-state Medicaid budget survey, states are using managed care and alternative payment models to improve quality and to help screen for social factors impacting health outcomes. In Fiscal Year 2016, 26 states reported requiring or encouraging managed care organizations to screen for social needs and provide referrals to services, and four states intended to do so in FY 2017.⁸

AMA POLICY

AMA Policy H-160.909, “Poverty Screening as a Clinical Tool for Improving Health Outcomes,” encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.

Policy H-160.919, “Principles of the Patient-Centered Medical Home,” outlines the principles of the patient-centered medical home (PCMH), one which states that care is to be coordinated and/or integrated across all elements of the complex health care system and the patient’s community. This policy further calls for care that is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The policy asserts that the payment structure should appropriately recognize the added value of the PCMH and pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources, and recognize case mix differences in the patient population being treated within the practice.

Policy D-478.995, “National Health Information Technology,” directs AMA advocacy in the health IT arena, and specifically calls for continued research and physician education on EHR design and features that can improve health care quality, safety and efficiency.

Policy H-295.874, “Educating Medical Students in the Social Determinants of Health and Cultural Competence,” states that our AMA: (1) Supports efforts designed to integrate training in SDH and cultural competence across the undergraduate medical school curriculum to assure that graduating
medical students are well prepared to provide their patients safe, high quality and patient-centered care; (2) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of SDH and cultural competence in the undergraduate medical school curriculum; and (3) Recommends studying the integration of SDH and cultural competence training in graduate and continuing medical education and publicizing successful models.

DISCUSSION

Screening for SDH does not need to be administered by a physician and it can be performed upon check in, or while rooming the patient, so that it does not disrupt the flow of the visit while promoting more comprehensive care. Screenings are most frequently conducted by the other members of the care team such as the registration staff, medical assistants, and care coordinators. Having knowledge about a patient’s SDH may help physicians understand barriers patients face in adhering to recommended treatments. For example, if a patient screens food insecure, they may not be able to fill prescriptions or take medication as recommended. Knowing such information in advance, may help physicians engage in collaborative discussions with their patients regarding treatment options that make sense for the patient.

Key principles for expanding access to screening tools for SDH are reflected in existing AMA policy. Several tools for screening are publicly available for physician and care team use and have been incorporated into some EHR products. Furthermore, our AMA is developing a related STEPS Forward module to increase physician awareness and understanding of SDH. Also, national initiatives exist to incentivize providers for screening for SDH. Based on these factors, the Board of Trustees believes existing policy and actions regarding access of screening tool are sufficient. However, AMA Policy D-478.995, “National Health Information Technology,” could be amended by addition to urge EHR vendors to adopt SDH templates without adding further cost for physicians.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 711-A-17 and 816-I-17 and the remainder of the report be filed.

1. That the following policies be reaffirmed:

   • H-160.909, “Poverty Screening as a Clinical Tool for Improving Health Outcomes”
   • H-160.919, “Principles of the Patient-Centered Medical Home”
   • H-295.874, “Educating Medical Students in the Social Determinants of Health and Cultural Competence”

2. That Policy D-478.995, “National Health Information Technology,” be amended by addition to read as follows:

   1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

   2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health
systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt SDH templates without adding further cost for physicians.

Fiscal Note: Less than $250
REFERENCES
REPORT OF THE COUNCIL ON MEDICAL SERVICE

Subject: Health Plans’ Medical Advice
(Resolution 705-A-17)

Presented by: Paul A. Wertsch, MD, Chair

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

At the 2017 Annual Meeting, the House of Delegates referred Resolution 705, “Regulating Health Plans Medical Advice,” which was introduced by the Washington Delegation. The Board of Trustees assigned this resolution to the Council on Medical Service for a report back to the House of Delegates. Resolution 705-A-17 asked:

That our American Medical Association (AMA) define when medical advice is the practice of medicine, and study options for regulating medical advice given by health plans.

This report provides background on medical advice services provided by health plans, discusses California’s regulation of telephone medical advice services, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Health plans have been offering medical advice services (eg, “nurse lines,” “ask a nurse,” or “telephone triage”) since at least the 1980s, when managed care organizations began using health professionals (predominantly nurses) to manage demand and also prevent unnecessary physician office and emergency department visits. Although Resolution 705-A-17 pertains to medical advice services provided by health plans, some hospitals and large physician practices also operate telephone and/or online medical advice services. The “advice” is usually provided by nurses using detailed screening protocols to answer questions, provide basic health information, or determine when enrollees should be urged to go to a hospital emergency department or make an appointment with a physician. Although these services may be provided directly by a health plan or care provider, most large health plans contract with vendors to operate their medical advice services.

Many health plans advertise medical advice services as a no-cost benefit for enrollees who can call nurse lines, or fill out online “e-visit” questionnaires, to ask basic health questions at any hour of the day or night. Assessments of users’ health care needs are obviously limited, however, because enrollees are not physically observed. Many health plans also offer condition-specific programs—such as those for pregnant women or chronic disease patients—that provide text messages to enrollees in addition to online or telephone access. Patient navigator and nurse advocate programs are also offered by health plans to enrollees with complex medical conditions.

Health plans include an assortment of legal disclaimers when advertising medical information and advice services. Most clarify that call center or online staff (typically nurses) cannot diagnose conditions or prescribe or recommend treatment, and further state that the information provided is

© 2018 American Medical Association. All rights reserved.
not a substitute for care by physicians. Some services specify that staff cannot give medical advice, while others advertise themselves as medical advice lines. Although these services are likely to produce some cost savings by reducing unnecessary physician and emergency department visits, there have been questions and concerns over the years regarding how they are managed, whether staff are qualified to evaluate enrollees’ medical needs and make appropriate referrals, and how care is coordinated with enrollees’ medical homes or treating physicians. Additionally, there have been allegations that medical call centers, in particular, have engaged in the unauthorized practice of medicine. Call centers operated by health plans and hospitals can voluntarily seek accreditation by meeting a set of “health call center” standards developed by the Utilization Review Accreditation Committee, a nonprofit accrediting organization.

Resolution 705-A-17 posits that medical advice given by health plans may be considered the practice of medicine when it is specific to a person’s illness or injury. It is the policy of the AMA that the diagnosis of disease and diagnostic interpretation of studies for specific patients constitutes the practice of medicine. Because states are responsible for providing medical licenses, each state regulates the practice of medicine and defines conduct that constitutes the practice of medicine within its jurisdiction. States may define the practice of medicine slightly differently. Each state could similarly define “medical advice” in statute or regulation. However, a Lexis search for state regulations defining “medical advice” or “telephone medical advice” turned up just a single result—California’s regulation of telephone medical advice services, which was cited in Resolution 705-A-17.

California regulation of telephone medical advice services

California enacted legislation in 2003 to protect consumers receiving telephone medical advice services. California Health and Safety Code §1348 requires that telephone medical advice must be provided by appropriately licensed health professionals, and prohibits other staff from misrepresenting themselves as licensed, certified or registered professionals. “Telephone medical advice” is defined in the Code as a “telephonic communication between a patient and health care professional in which the health care professional’s primary function is to provide the patient a telephonic response to the patient’s questions regarding his or her or a family member’s medical care or treatment.” It includes assessment, evaluation, or advice provided to patients and their families. Health care service plans providing telephone medical advice are required to make physicians and surgeons available on an on-call basis, and must maintain records—including transcripts of conversations and complaints—for five years. Until 2017, when the Telephone Medical Advice Services Bureau was repealed, businesses engaged in telephone medical advice were required to register with the state.

Neither “medical advice” nor “telephone medical advice” is defined in AMA policy, in part because these terms do not have universally accepted legal definitions and could vary by state. However, it is important to ensure that medical advice services—which do not allow users to be physically examined—are not engaged in the practice of medicine, which generally involves the diagnosis and treatment of disease or injury. Health plans’ medical advice services are not usually used for these purposes. If they were, the services could be considered telemedicine in those states that do not exclude telephone calls from their definition of telemedicine.

Apart from medical advice services, many health plans offer their own telemedicine services whereby enrollees can access physicians virtually via computer or mobile device, usually for a fee. Some health plans also contract with vendors offering home visits and other care management services that constitute the practice of medicine and are provided outside of established patient-physician relationships. While the Council has concerns regarding the expansion of care
management services—including telemedicine—that are increasingly provided by health plans, and the coordination of these services with patients’ treating physicians, the scope of this report is limited to health plan medical advice services.

AMA POLICY

Policy H-140.919 affirms that the physician-patient relationship should be reinforced and not disrupted by direct communications from health plans to patients regarding clinical matters. This policy further states that health plan communications to patients promoting improved outcomes through evidence-based approaches (eg, promotion of preventive measures or disease management programs) should reinforce the primacy of the patient-physician relationship, and also be sensitive to confidentiality as well as patients’ concerns about their health status. If a health plan directly communicates with a patient, Policy H-140.919 asserts that a copy of that communication should be sent to the patient’s primary physician.

Disease management and demand management, through the use of telephone triage by health plans, is addressed by Policy H-285.944. Principles outlined in this policy specify that referral algorithms or protocols used in telephone triage should be developed by knowledgeable physicians, and should be updated regularly; telephone triage centers should routinely inform primary or principal care physicians of the disposition of all calls received from their patients; telephone counseling and triage should be performed by health professionals with a level of knowledge and training no less than that of a registered nurse; and qualified physicians should be readily accessible for consultation and second-level triage to the nurses or other health professionals providing telephone counseling or triage. Additional policy on “phone counseling” (Policy H-160.935) maintains that medical phone counseling services must appoint a physician director, and that the director is ultimately responsible for telephone triaging patients, updating the protocols and algorithms used by non-physicians, and maintaining accountability for patients until referrals have been effected by accepting physicians.

Guidelines for patient navigator and patient advocacy programs, including those offered by health plans, are outlined in Policy H-373.994. This policy states that these programs should establish procedures to ensure direct communication between patient navigators and the patient’s medical team, and that navigators should refrain from activity that could be construed as clinical in nature.

Policy H-35.971 affirms that the diagnosis of disease and diagnostic interpretation of studies for specific patients constitutes the practice of medicine. Policy H-285.998[5] states that physicians who make judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions. Policy H-285.995[7] reaffirms that the portion of AMA model state legislation that calls for certain elements of utilization review to be defined as the practice of medicine.

The practice of medicine by non-physicians is the focus of Policy H-160.949. This policy actively opposes legislation allowing non-physicians to engage in the practice of medicine without physician training or physician supervision. The AMA also opposes regulations and legislation that would interfere with and/or redefine the practice of medicine (Policy H-390.994). Policy H-285.954 states that certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician regardless of the practice setting (eg, health plan, physician practice, hospital or integrated delivery system).
The AMA has substantial policy on telemedicine, including Policy H-480.946, which outlines principles guiding appropriate coverage of and payment for telemedicine services, and also how to establish a valid patient-physician relationship via telemedicine. This policy also maintains that physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services, and be licensed in the state where the patient receives services, or be providing services as authorized by that state’s medical board. Additional principles affirm that telemedicine services must be consistent with state scope of practice laws, and that the provision of telemedicine services must include care coordination with the patient’s medical home and treating physicians, who should be provided with a copy of the medical record. Principles for the supervision of non-physician providers when telemedicine is used are outlined in Policy H-160.937, which asserts that in all settings and circumstances, physician supervision is required when non-physician providers deliver services via telemedicine. A compilation of AMA policy on telemedicine can be found at https://www.ama-assn.org/sites/default/files/media-browser/public/arc-public/telemed-policy.pdf.

DISCUSSION

The Council’s deliberations distinguished between health plans’ medical advice services, which are the subject of referred Resolution 705-A-17, and medical management and telemedicine services offered by plans that explicitly constitute the practice of medicine. Policies H-35.971, H-285.998 and H-285.995, which delineate the practice of medicine, are recommended for reaffirmation. Medical advice services are typically provided by health plans via telephone or online questionnaire, and are offered to enrollees free of charge. Nurses usually provide the service, with industry disclaimers clarifying that medical advice service staff cannot diagnose conditions or recommend specific treatments, and that the information provided is not a substitute for physician care. AMA policy on health plan disease management programs and demand management through telephone triage (Policy H-285.944), as well as phone counseling (H-160.935), remain relevant to the Council’s discussion and are recommended for reaffirmation. The Council further recommends reaffirmation of Policy H-140.919, which maintains that the physician-patient relationship should be reinforced and not disrupted by direct communications from health plans to patients regarding clinical matters, and that in cases where a health plan directly communicates with a patient, a copy of that communication should be sent to the patient’s primary physician.

The Council recognizes that health plans’ medical advice services offer enrollees convenient, 24/7 access to nurses or other health professionals for general information and advice. The Council further recognizes that these services may be used to manage overall costs to the plan and that safeguards may be needed to ensure that patients receive timely and appropriate care. Because state medical practice laws vary, it would be difficult for the Council to precisely define all of the circumstances in which medical advice crosses over into the practice of medicine. Instead, the Council recommends a more general policy statement: That real-time interactions between health plans and enrollees that are utilized for patient assessments and result in the creation of treatment plans constitute the practice of medicine.

The Council also utilized existing AMA policy and the California regulation to develop guidelines that health plans’ medical advice services should adhere to. Accordingly, the Council recommends that AMA policy affirm that medical advice services provided by health plans should adhere to a series of guidelines related to their primary goals, relevant requirements under state law, staff knowledge and training, physician availability, policies and procedures regarding efficiency and responsiveness to treating physicians, assurance that non-clinical staff are not providing medical advice, and disclosure of training and credentials. Finally, the Council recommends that the AMA
work with interested state medical associations to advocate for appropriate policy on health plans’
medical advice services.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution
705-A-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-35.971, which states that
the diagnosis of disease and diagnostic interpretation of studies for specific patients constitutes
the practice of medicine; Policy H-285.998, which states that physicians who make judgements
or recommendations regarding the necessity or appropriateness of services or site of service
should be licensed to practice medicine; and Policy H-285.995, which reaffirms that certain
elements of utilization review be defined as the practice of medicine. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-285.944, which outlines principles that should guide health
plans’ disease management programs and demand management through telephone triage, and
Policy H-160.935 on phone counseling. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-140.919, which maintains that the physician-patient
relationship should be reinforced and not disrupted by direct communications from health plans
to patients regarding clinical matters, and that in cases where a health plan directly
communicates with a patient, a copy of that communication should be sent to the patient’s
primary physician. (Reaffirm HOD Policy)

4. That it be the policy of our AMA that real-time interactions between health plans and enrollees
that are utilized for patient assessments and result in the creation of treatment plans constitute
the practice of medicine. (New HOD Policy)

5. That our AMA policy affirm that medical advice services provided by health plans should
adhere to the following guidelines:

a) The primary goals of health plans’ medical advice services should be to inform, educate and
empower patients to make good health care choices and receive timely and appropriate care.
These services should not be used to assess patients in order to inform diagnosis or
treatment.

b) Health plans’ medical advice services should comply with state licensure laws, state
medical, nursing, or other relevant practice acts, state scope of practice laws, and other
relevant requirements within the state in which enrollees receive services.

c) Staff providing health plans’ medical advice services should have a level of knowledge
and training no less than a registered nurse (eg, nurse with a bachelor of science in nursing,
advanced practice registered nurse, or physician assistant) and be appropriately licensed in
the state in which enrollees receive services.

d) Qualified physicians should be available for consultation at all times that the medical advice
service is advertised as available.

e) Health plans should have policies and procedures in place that allow medical advice
services to quickly and effectively respond to enrollees’ health concerns.
f) Health plans should have policies and procedures in place to ensure that medical advice service providers routinely provide feedback to enrollees’ treating physicians regarding the nature of the enrollees’ contacts.

g) Health plans should ensure that non-clinical staff who may be screening enrollee calls or emails for the medical advice service are neither providing medical advice nor making medical decisions.

h) Health plans’ medical advice services staff should fully disclose relevant training and credentials, and not misrepresent themselves to users. (New HOD Policy)

6. That our AMA work with interested state medical associations to advocate for appropriate policy on health plans’ medical advice services. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

2 URAC health call center accreditation. Available online at: https://www.urac.org/programs/health-call-center-accreditation
4 Id.
5 Id.
6 State of California Telephone Medical Advice Services Website. Available online at: http://www.dca.ca.gov/tmas/
EXECUTIVE SUMMARY

The Council on Medical Service initiated this report to provide an overview of the current financing mechanisms for long-term services and supports (LTSS) and to raise awareness about the importance of identifying sustainable methods of financing LTSS in light of a growing aging population. This report builds off of the American Medical Association’s long-standing policy on LTSS and presents policy recommendations to modify the current financing structure of LTSS with options that weave together financing reforms through publicly funded programs and private insurance.

LTSS refers to the range of clinical health and social services that assist individuals in their activities of daily living. In 2015, national spending for LTSS was about $331 billion, up from $310 billion in 2013. Medicaid accounts for over half of national spending on LTSS and is the primary payer across the nation for long-term care services. Demand for long-term services and supports (LTSS) is expected to double in the next 30 years and is fiscally unsustainable. For example, one funding source, long-term care insurance (LTCI), is too expensive and complex for most consumers, and its traditional policy design has not been sustainable. With few affordable options in the private insurance market and limited coverage under Medicare, individuals with insufficient resources rely on Medicaid to fund their LTSS needs, which puts a strain on Medicaid financing that will worsen as baby boomers age. More effective methods of financing LTSS and expanding the availability and affordability of LTCI would help not only alleviate the financial strain on public payers but also avert the need for individuals to deplete their retirement funds and savings to pay for LTSS or to be eligible for Medicaid.

The Council recognizes that there may be no single, comprehensive solution to address the growing demand for LTSS and that the challenges to affordable and politically viable LTSS financing mechanisms are varied and complex. Though its recommendations are not intended to solve the LTSS financing crisis in its entirety, there is an opportunity to formulate a series of pragmatic recommendations to modify the current financing structure. The Council notes that a growing consensus has emerged around a set of incremental steps that have the ability to improve the availability and affordability of LTSS. To that end, the Council proposes a multi-pronged approach to alter the financing and viability of LTSS through a mix of public and private reforms. The Council’s recommendations are intended to provide feasible steps to alleviate the financial strain of providing LTSS on Medicaid and families. The Council offers these recommendations as a pragmatic step forward to address the needs of an aging population and help shift away from an LTSS system dependent on insolvency and last-resort public financing to a sustainable system of meaningful insurance.
This report, initiated by the Council, addresses the growing need for long-term care services and supports (LTSS) in the US. The report provides an overview of LTSS; details the cost and need for LTSS; discusses the lack of public education on LTSS; provides a summary of the current financing structure for LTSS; outlines possible LTSS financing mechanisms; summarizes relevant policy; and presents policy recommendations to modify the current financing structure of LTSS with options that weave together financing reforms through publicly funded programs and private insurance.

BACKGROUND

Long-term services and supports (LTSS) refers to the range of clinical health and social services that assist individuals in their activities of daily living (ADL) when these individuals are limited or unable to care for themselves. ADLs include eating, bathing, dressing, and instrumental tasks like medication management, house cleaning, and meal preparation. Unlike medical care, LTSS are function-based and holistic in nature. In 2013, national spending for LTSS was $310 billion and by 2015, that figure grew to $331 billion. Medicaid spending accounts for over half of national spending for LTSS and is the primary payer for LTSS across the nation.

NEED FOR REFORM

The need for LTSS is expected to increase sharply in the coming decades; however, a possible funding source, long-term care insurance (LTCI), is too expensive and complex for most consumers, and its traditional policy design has not been sustainable. With few affordable options in the private insurance market and limited coverage under Medicare, individuals with insufficient resources rely on Medicaid to fund their LTSS needs, which puts a strain on Medicaid financing that will worsen as baby boomers age. More effective methods of financing LTSS and expanding the availability and affordability of LTCI through a mix of public and private reforms would help not only alleviate the financial strain on public payers but also avert the need for individuals to deplete their retirement funds and savings to pay for LTSS or to be eligible for Medicaid.

COST AND NEED FOR LTSS

The number of Americans needing LTSS in 2010 was 12 million, and it is expected that by 2050, 27 million Americans will need LTSS. This increased demand for LTSS is driven by a life expectancy that remains relatively high, the aging of the large baby boomer generation, and advances in technology that allow people with chronic illness and disabling conditions to live longer.
The number of elderly people is expected to more than double in the next 40 years. Baby boomers began turning 65 in 2011, and, within the next 20 years, the 65+ population will double and the 80+ population will more than double. Additionally, it is estimated that at least 70 percent of baby boomers will need some form of LTSS at some point in their lives, and 40 percent are expected to require nursing home care.5

Not only is the size of the baby boomer generation a strain on the LTSS system, but baby boomers are also more likely than previous generations to be divorced, have fewer children, and have more children in the workforce, making informal family caregiving less likely. Further, many baby boomers have not saved enough for retirement and appear to be unprepared for unplanned expenses such as LTSS. The average retirement savings for baby boomers is about $75,000 while the cost of providing LTSS is significant.6 For example, in 2017 the average annual cost for a community-based adult day-care center was $16,900; a home health aide was approximately $49,000; and the average annual cost to live in a nursing facility was $97,455. The need for LTSS is one of the primary risks to retirement security, and some aging individuals will have to deplete their retirement savings and overwhelm funding sources such as Medicaid to meet their LTSS needs.

There is great variation in LTSS spending among individuals. Although some individuals will not have any LTSS needs, others will have significantly high spending. About 27 percent of individuals turning 65 will have LTSS costs of at least $100,000 over their lifetimes, and 15 percent will have costs that exceed $250,000.7

PAYING FOR LTSS

The responsibility of paying for LTSS is shared among the elderly, people with disabilities, family, friends, volunteer caregivers, communities, states, and the federal government. However, this shared-responsibility system is severely stressed and increasingly will become unable to withstand the swelling demand for LTSS.8

LTSS are expensive, with institutional care costs far exceeding costs for home and community-based services (HCBS). Aside from unpaid care provided by friends or relatives, LTSS costs often exceed what individuals and families can afford out-of-pocket. Therefore, many with LTSS needs rely on publicly funded programs to help pay for or supplement the cost of their care needs.

Many people expect Medicare to be their primary source of health coverage in retirement, but long-term care (LTC) is only covered in limited circumstances and for a short period of time.9 Medicare only pays for LTC for individuals requiring skilled services or rehabilitation care, generally following a hospitalization. Importantly, there is an expectation that the beneficiary will recover from the condition. In a nursing home, Medicare pays for a maximum of 100 days; however, the average covered stay is about 22 days. If a beneficiary is receiving skilled home health or other skilled in-home services, commonly these are provided only for a short period of time. Notably, Medicare does not pay for non-skilled ADL, which make up the majority of needed LTC services.

Already, about 40 percent of state Medicaid budgets go toward LTSS.10 Medicaid pays for most of LTSS while Medicare post-acute care pays for 23 percent of LTSS. The remaining sources of funding include out-of-pocket spending, LTCI, other private sources, and other public sources.11

Because many middle-class people fail to anticipate and plan for their LTC needs, Medicaid has effectively become the default payer instead of a safety net for the poorest individuals. This creates an enormous strain in funding and threatens services for the poorest and most vulnerable.
Individuals are only eligible for public LTC coverage through Medicaid after they spend down most, if not all, of their personal liquid financial resources. In order to qualify for Medicaid services, one’s income must be below a certain level and must meet minimum state eligibility requirements based on the amount of assistance needed with ADL. Generally, in order to qualify for Medicaid, one cannot have assets exceeding $2,000, which excludes a car or home if the applicant intends to move back into the home or a spouse or dependent lives in the home.

Medicaid is the default payer for about 65 percent of nursing home residents.

Individuals and families must pay for LTSS that are not covered or partially covered by a public or private insurance program. Individuals pay for about 53 percent of their total LTSS expenditures out-of-pocket, typically through savings, retirement funds, or borrowed funds such as a reverse mortgage. For those who lack sufficient personal resources to pay for LTSS out-of-pocket, Medicaid is the primary payer. As baby boomers begin to need these services and supports, states will face a great challenge balancing their budgets with an increasing amount used in financing LTSS under Medicaid.

LACK OF PUBLIC EDUCATION

Exacerbating the lack of funding for LTSS is the public’s misunderstanding of how much such care costs and how it is currently financed. Many Americans mistakenly believe that Medicare will pay for their LTSS needs. A recent survey conducted by the SCAN Foundation found that 57 percent of respondents said that they expect to rely on Medicare for LTSS. Only 25 percent of respondents think that they will get help from Medicaid, and many respondents are counting on Social Security to finance LTSS needs, even though average Social Security benefits would pay for less than 15 percent of the cost of a typical nursing home and perhaps one-third of the cost of assisted living.

Some others know parents or friends who have received LTSS through Medicaid and fail to understand the limits of Medicaid coverage and strict eligibility criteria. In order to qualify for Medicaid, individuals have to have spent practically all of their assets or have appropriately given away or transferred them at least five years before the date that they are applying for Medicaid benefits. Some generally have a belief that the government will ultimately pay for any future LTSS needs, further encouraging them to avoid the expense and discomfort of purchasing LTCI.

HURDLES TO LONG-TERM CARE INSURANCE ENROLLMENT

LTCI provides an opportunity to shift some of the cost of providing LTSS from Medicaid but has remained a relatively niche product. Not only is LTCI often cost-prohibitive, but also, often potential purchasers do not believe that they will need the benefit later in life, are in denial about the probability of future care needs, or erroneously believe that Medicare will pay for their LTSS needs. Less than 10 percent of individuals in their early 60s have LTCI, which puts pressure on the Medicaid program to bear most of this burden.

Because of the declining LTCI market, many insurance carriers are reluctant to offer LTCI due to the difficulty of predicting costs far in the future and the risk that many beneficiaries will live for a long time. This reluctance to participate in the LTCI market and inability to predict future costs drives up premiums, especially for those in their 60s when they are likely to have preexisting conditions that may disqualify them from coverage and fewer working years to pay premiums that usually increase with age.
In addition, LTCI marketing materials are often confusing, and, at this stage in life, consumers are also balancing other competing financial demands such as saving for their own retirement and paying for children’s college tuition.

PUBLIC CATASTROPHIC INSURANCE

Seventy percent of older Americans will need LTSS at some point in their lives. Fifteen percent of the population will have significant LTSS expenses representing lifetime costs of over $250,000. For this high-cost population in particular, personal assets and informal family caregiving will not meet their care needs. The vast majority of those facing catastrophic costs must deplete their personal savings and sell assets to qualify for Medicaid.

In 2015, Milliman, Inc. and the Urban Institute conducted a microsimulation analysis of financing options for LTSS. The analysis found that a universal approach would not only be less expensive for individuals than a voluntary approach but also save the Medicaid program and states significant funds and avert out-of-pocket spending. For example, they projected that a mandatory public catastrophic insurance plan would reduce Medicaid LTSS spending by 35 percent in 2070, while a voluntary subsidized public catastrophic plan would reduce Medicaid LTSS by 7 percent.

Additionally, the analysis found that public catastrophic plans that cover LTSS later by providing back-end benefits would offset more Medicaid spending than alternatives that cover only front-end costs. Without the ability to accurately predict future costs, many insurers have instituted significant rate increases further driving potential buyers out of the private insurance market. However, a public catastrophic insurance option could ease the reluctance of insurance carriers to offer LTCI and the reluctance of consumers to purchase LTCI thereby reducing the cost of private LTCI. Importantly, a back-end catastrophic program would have the effect of stabilizing the private insurance market. For example, a back-end catastrophic program with a five year waiting period and a $100 per day lifetime benefit would cost a median-income worker about $300 per year.

Insurers will only participate in the private market on any meaningful scale if they have enough information to accurately price their products, and a public back-end catastrophic program allows for accurate prediction. The path to affordable private LTCI depends on a competitive and growing private insurance market, which relies on predictability. Offering public back-end insurance could encourage new private insurers to enter the market in the context of well-defined public and private responsibilities.

LTCI BENEFIT UNDER MEDIGAP AND MEDICARE ADVANTAGE

Most seniors are enrolled in either Medicare with a supplemental insurance policy (Medigap) or a Medicare Advantage (MA) plan, but they do not have LTCI. Medigap insurance is offered on a guaranteed basis without medical underwriting at the time a beneficiary enrolls in Medicare. Many MA plans also provide supplemental benefits for services that are not covered under Medicare Part A or Part B. MA plans can provide either mandatory supplemental benefits that generally must be provided to all beneficiaries or optional supplemental benefits in which the MA plan provides the beneficiary with the option of enrolling in coverage of additional services not covered by Medicare in exchange for additional premiums that are paid by the beneficiary.

In February 2018, Congress passed the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care (CHRONIC) Act that will, for the first time, allow MA plans to pay for some LTSS. While the law does not change the rules for traditional FFS Medicare, it allows MA...
plans to include in their benefit packages nonmedical services such as home-delivered meals or transportation to and from medical appointments.

Milliman, Inc. and the Bipartisan Policy Center analyzed a potential limited LTSS benefit for Medigap and MA plans wherein the Centers for Medicare & Medicaid Services (CMS) would amend Medigap and MA requirements to permit plans to offer existing benefits as well as a new limited and voluntary LTSS benefit. In the model analysis, beneficiaries could choose to enroll in and pay corresponding premiums to cover the cost of the new benefit. When estimating the added cost of the benefit to Medigap or MA premiums, one analysis assumed a $75 daily benefit with a 180-day elimination period that would need to be satisfied prior to commencement of the benefit. Consistent with existing Medigap policies, beneficiaries would have a one-time option to purchase this coverage when enrolling in Medicare. The analysis suggests that this policy could result in premiums of $35-$40 per member per month.

RESPITE CARE

A significant amount of LTSS is provided by unpaid caregivers who are typically family members or friends. Though potentially rewarding, caregiving can be strenuous physically, mentally, and financially. Many caregivers often miss work time or leave the labor market altogether thereby eroding their ability to accumulate resources for retirement and their own LTC needs. Though valuing unpaid care is difficult, it is estimated that, in 2013, 40 million family caregivers in the US provided 37 billion hours of care to adults with ADL limitations representing a total economic value of unpaid caregiving of $470 billion. Family caregivers on average spend 13 days per month on tasks such as shopping and housekeeping and six days per month on personal tasks such as feeding, dressing, and grooming. Taken together, the average individual with LTSS needs who relies exclusively on family for help receives about 173 hours of care over the course of a month, which is equivalent to a full-time job. Without this family-provided support, the economic cost of providing LTSS would rise sharply and worsen the current financing crisis.

Respite care helps individuals needing assistance to stay in their homes while giving their caregivers a reprieve from caregiving, which can prevent the caregiver from declining physically or emotionally. Currently, respite care benefits are only available for Medicare beneficiaries who are enrolled in Medicare’s hospice benefit, a benefit that is only available for beneficiaries expected to die within six months.

The Urban Institute and the Bipartisan Policy Center analyzed the cost of a potential respite care benefit in Medicare and MA that would be triggered when certain Medicare providers determined that respite care was needed. Among several analyses, one found that the 10-year federal budgetary cost of a 96-hour respite benefit would cost $29 billion if beneficiaries with spousal caregivers were eligible for the benefit.

HOME AND COMMUNITY-BASED SETTINGS (HCBS)

Historically, states and the federal government have limited the use of Medicaid-funded LTSS by restricting eligibility for services and providing care primarily in institutional settings such as nursing homes and residential facilities. However, there has been significant agreement that the current bias toward LTSS being delivered in an institution should be eliminated. Not only are HCBS significantly cheaper than institutional care, but also, there has been a growth in beneficiary and societal preferences for them. Over the years, states have used waivers and state plan options
to enable Medicaid-funded LTSS to be delivered in other less expensive settings. Progress has been made at the community level in finding ways to keep seniors and people with disabilities out of institutions and in the community. HCBS keep people happier, less isolated, and can be provided more effectively and cheaper than nursing home facilities. Expanding HCBS could provide individuals with more flexibility in how they receive LTSS and a higher quality of life.

There has also been a call to better integrate medical care and social care, predominantly for the dually eligible population. The Program of All-Inclusive Care for the Elderly (PACE) both supports HCBS and improves the delivery of LTSS through better care integration for this particular population. PACE is a program under Medicare wherein states can elect to provide services to Medicaid beneficiaries as an optional Medicaid benefit. The PACE program becomes the sole source of Medicaid and Medicare benefits for participants. It provides comprehensive medical and social services to certain frail, elderly individuals enabling them to remain in the community rather than receive care in a nursing home. The PACE program is an interdisciplinary team of health professionals providing participants with coordinated care. Notably, financing for the program is bundled, allowing the providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans.

RELEVANT AMA POLICY

Policy H-280.991 addresses financing of LTC and outlines relevant principles and policy proposals for LTC. It states that programs to finance LTC should cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual and coordinate benefits across different LTC financing programs. Policy H-210.994 echoes providing LTC services in the least restrictive setting by affirming support of home health care as an alternative to nursing home or institutional care. Further, Policy H-280.991 suggests providing coverage for the medical components of LTC through Medicaid for all individuals with income below 100 percent of the poverty level and providing sliding scale subsidies for the purchase of LTCI coverage for individuals with income between 100-200 percent of the poverty level.

Policy H-280.991 also considers tax incentives and employer-based LTC coverage to help fund LTC including creating tax incentives to allow individuals to prospectively finance the cost of LTC coverage and encouraging employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTCI premiums and expenses. Additionally, the policy supports use of a tax deduction or credit to encourage family caregiving.

Furthermore, Policy H-280.991 states that consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional Medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to provide an environment within their states that permits innovative LTC financing and delivery arrangements, and assures that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. Additionally, consistent with other AMA policy on state-based innovation, Policy H-280.991 supports health system reform legislative initiatives that could increase state flexibility to design and implement long-term care delivery and financing programs.
Policy H-165.852 supports legislation promoting the establishment and use of Health Savings Accounts (HSAs) and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care.

Policy H-290.982 supports allowing states to use LTC eligibility criteria that distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related LTC needs; and supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new LTC infrastructures and to encourage expansion of LTC financing to middle-income families who need assistance.

DISCUSSION

The Council’s recommendations are intended to provide feasible steps forward to alleviating the financial strain of providing LTSS on Medicaid and families. The Council’s recommendations are not intended to solve the LTSS financing crisis in its entirety. The Council recognizes that a growing consensus has emerged around a set of incremental steps that have the ability to improve the availability and affordability of LTSS. To that end, the Council proposes a multi-pronged approach to alter the financing and viability of LTSS through a mix of public and private reforms. Though the following recommendations are consistent with Policy H-280.991, the Council considers these recommendations to be distinct and with a broader view of LTSS financing.

The Council believes it is important to help consumers prepare thoughtfully for their LTSS needs and to provide individuals with a reasonable assessment of the likelihood of future need. Accordingly, the Council recommends reaffirming Policy H-280.991, which states that consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional Medigap policies.

Regarding private reform, the Council firmly believes in the importance of strengthening and improving the private insurance market. There are a number of steps that may be taken to revitalize the market for private LTCI. First, the Council recommends a policy statement to standardize and simplify private LTCI to achieve increased coverage and improved affordability. Additionally, Policy H-280.991 encourages employers to offer LTCI policies as a part of employee benefit packages, and the Council recommends expanding this principle to support adding LTCI coverage as part of workplace automatic enrollment with an opt-out provision. In this case, enrollment in the LTCI coverage would be paid through annual premiums that are almost half the cost of typical current-market LTCI policies. Additionally, the Council stipulates that these employer-offered plans should be available to both current employees and retirees.

To further improve the market for private insurance, the Council recommends allowing retirement savings to be used for LTCI premiums. Such a strategy includes supporting penalty-free withdrawals from employer-based retirement savings accounts for purchase of private LTCI. The Council notes that Policy H-280.991 already supports the creation of tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs for payment of LTC insurance premiums and expenses. Similarly, the Council recommends reaffirming Policy H-165.852 promoting the establishment and use of HSAs and allowing the
The tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care. The Council is confident that such private reforms would reduce premium costs while reaching segments of the population that are not yet served by private LTCI.

As another step toward developing the private insurance market, the Council recommends exploring innovations in LTCI product design. Such innovations may include LTCI covering home and community-based LTC needs as well as marketing products with health insurance, life insurance, or annuities. Not only is home and community-based care less expensive than traditional facility-based care, but also, most people are able to stay at home and avoid nursing home care altogether.40

The Council believes increasing the availability of LTCI is vital to a sustainable financing structure moving forward. As such, the Council recommends supporting the ability of Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit, or as a separate insurance policy, financed through additional premiums paid by the beneficiaries who choose to enroll. Similarly, the Council recommends supporting the implementation of the CHRONIC Act allowing MA plans to offer social supports in benefit packages. Correspondingly, the Council recommends permitting a respite care benefit as part of Medigap and MA policies.

There is widespread agreement among advocacy organizations and think tanks of the need for a public catastrophic program for individuals with extraordinary LTSS costs to protect against poverty and bankruptcy.41 There is also public support for such a program. A recent survey found that about two-thirds of people favor a public catastrophic insurance program.42 Many agree that a public catastrophic option should help cover the back-end risk of LTSS costs that discourages private insurers from offering comprehensive protection. Back-end catastrophic coverage could be compared to the concept of reinsurance in that it may protect against premium increases in the private LTCI market by serving as a safety-net to those high-cost individuals who may require LTSS for a long period of time. It would be used in the event of catastrophic LTSS expenses after a period of using private LTCI or self-funding. Therefore, such a program could stabilize the private insurance market and allow insurers to focus on shorter-term, defined, and predictable coverage. The Council believes that a back-end public catastrophic insurance program could help shift away from the current welfare-based model and toward a system of insurance.

Consistent with Policy H-280.991 advocating for states to be permitted to pilot innovative LTSS financing and delivery arrangements, the Council suggests incentivizing states to expand the availability of and access to HCBS. Such services could help individuals remain in home and community settings for a longer period of time and relieve some of the burden of more costly LTSS care such as that provided in nursing homes. Increasing the availability of HCBS not only helps in eliminating the current bias in financing toward more expensive institutional care but also relieves family caregivers and allows them some time off. Furthermore, and consistent with Policy H-280.991 supporting the coverage of services in a coordinated manner in the least restrictive setting, the Council supports better integration of health and social services and supports, including the PACE.

Demand for LTSS will more than double over the next 30 years, and the challenges to affordable and politically viable LTSS financing mechanisms are varied and complex. While it is unlikely that there is one straightforward solution to the growing demand for LTSS, the Council offers these recommendations as a pragmatic step forward to address the needs of an aging population and help shift away from an LTSS system dependent on insolvency and last-resort public financing to a sustainable system of meaningful insurance.
RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-280.991 supporting consumer education regarding the likelihood of future need for long-term services and supports (LTSS) and the limits of public funding sources and supporting tax-free withdrawals from retirement savings accounts for payment of long-term care insurance (LTCI) premiums and expenses. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-165.852 supporting legislation promoting the establishment and use of Health Savings Accounts and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care. (Reaffirm HOD Policy)

3. That our AMA support policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability. (New HOD Policy)

4. That our AMA support adding LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees. (New HOD Policy)

5. That our AMA support allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI. (New HOD Policy)

6. That our AMA support innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities. (New HOD Policy)

7. That our AMA support permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy. (New HOD Policy)

8. That our AMA support Medicare Advantage plans offering LTSS in their benefit packages. (New HOD Policy)

9. That our AMA support permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit. (New HOD Policy)

10. That our AMA support a back-end public catastrophic long-term care insurance program. (New HOD Policy)

11. That our AMA support incentivizing states to expand the availability of and access to home and community-based services. (New HOD Policy)

12. That our AMA support better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly. (New HOD Policy)

Fiscal Note: Less than $500.
REFERENCES

6 Compare Long Term Care Costs Across the United States. Genworth. Available at: https://www.genworth.com/about-us/industry-expertise/cost-of-care.html
11 Calmus supra note 5.
13 Users of Long-Term Services and Supports. MACPAC Medicaid and CHIP Payment and Access Commission. Available at: https://www.macpac.gov/subtopic/long-term-services-and-supports-population/
14 Nursing Homes. AARP Public Policy Institute. Available at: https://assets.aarp.org/rgcenter/il/fs10r_homes.pdf
15 Howard Gleckman. Americans are Baffled by Long-Term Care Financing, But Want Medicare to Pay for It. Forbes. Available at: https://www.forbes.com/sites/howardgleckman/2017/05/30/americans-are-baffled-by-long-term-care-financing-but-want-medicare-to-pay-for-it/#76f8bed778fa
16 Cohen, supra note 11.
18 Rivlin, supra note 8.
19 Supra note 1.
21 Favreault, supra note 7.
22 Gleckman, supra note 15.
23 Nordman, supra note 10.
24 Cohen, supra note 11.
25 Supra note 1.
26 Id.
28 Supra note 1.
29 Id.
30 Id.
32 Cohen, supra note 11.
33 Supra note 1.
34 Id.
35 Id.
36 Id.
38 Program of All-Inclusive Care for the Elderly. Medicaid.gov Keeping America Healthy. Available at: https://www.medicaid.gov/medicaid/ltss/pace/index.html
39 Id.
41 Stuart Butler. JAMA Forum: Consensus Plans to Tackle Long-Term Care Costs. The JAMA Forum. Available at: https://newsatjama.jama.com/2016/02/24/jama-forum-consensus-plans-emerge-to-tackle-long-term-care-costs/
42 Gleckman, supra note 15.
EXECUTIVE SUMMARY

Genetic/genomic discoveries and precision medicine innovations are occurring simultaneously with payment and delivery reforms that require health care services to demonstrate value as a prerequisite for payment and coverage. The sustained push to contain health care costs has led to increased interest in alternative payment models (APMs) that incentivize high-quality, cost-effective care. Examples of well-known APMs include accountable care organizations, bundled payments, and patient-centered medical homes.

Precision medicine is a tailored approach to health care that accounts for individual variability in the genes, environment, and lifestyle of each person. It has the potential to revolutionize the diagnosis and treatment of disease and may ultimately help address rising health care costs by streamlining clinical decision-making, reducing unnecessary treatments and hospitalizations, tailoring treatments, reducing late-stage diagnoses, and improving outcomes over time.

APMs have the capacity to incentivize use of care protocols, clinical pathways and other decision support tools. However, the structure of APMs often requires cost savings within a specific window of time that may not account for improved outcomes downstream. The Council initiated this report to explore how APMs can support and integrate precision medicine services to provide high-quality, high-value health care. The Council’s recommendations encourage APMs to consider the value of precision medicine and to integrate precision medicine approaches into patient care where appropriate and when recommended by national medical specialty societies.
This report, initiated by the Council, explores how alternative payment models (APMs) can support and integrate genetic/genomic precision medicine services with the end goal of providing high-quality, high-value health care. Previous Council reports have discussed physician-focused APMs (Report 9-A-16) and barriers that interfere with the shift to these value-based payment models (Report 10-A-17). Policy developed via the I-17 Joint Report of the Councils on Science and Public Health and Medical Service is intended to facilitate more consistent payment and coverage for evidence-based genetic/genomic precision medicine services.

This report discusses APMs and precision medicine; describes clinical pathways and decision support tools; provides examples of APMs that incorporate precision medicine approaches; discusses AMA activity; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

Precision medicine, which is a tailored approach to health care that accounts for individual variability in the genes, environment and lifestyle of each person, has the potential to revolutionize diagnosis and treatment of disease and, in doing so, improve health outcomes downstream. It has the potential to more accurately diagnose disease, predict individual susceptibility to disease, detect the onset of disease at earlier stages, and reduce invasive procedures and no longer necessary screenings and treatments. Physicians already practice precision medicine by diagnosing and treating each patient according to his or her unique symptoms, history, and preferences. However, significant advances in technology—including the development of large-scale biological databases, powerful methods for characterizing patients (eg, proteomics, metabolomics, genomics, cellular assays, and mobile health technologies), and computational tools for analyzing large sets of data—have vastly expanded the ability to apply precision medicine principles to patient care.

Accelerated rates of genetic/genomic discoveries and clinical innovations are occurring simultaneously with payment and delivery reforms including the proliferation of APMs driven by the push for cost-containment strategies and value-based purchasing. Driven by the Affordable Care Act (ACA) and Medicare Access and Chip Reauthorization Act (MACRA), the Centers for Medicare & Medicaid Services (CMS) has developed and implemented a number of initiatives to test APMs.

New health care payment and delivery models focus on value and require that health care services demonstrate their value to patients and the health care system as a prerequisite for payment and coverage. The sustained push to contain health care costs has led to increased interest in APMs that incentivize high-quality, cost-effective care. Examples of well-known APMs include accountable
Precision medicine holds the potential to improve patient care and may ultimately help address rising health care costs overall by streamlining clinical decision-making, reducing unnecessary treatments and hospitalizations, tailoring treatments, reducing late-stage diagnoses, and improving outcomes over time. For example, genotype testing of patients initiating warfarin treatment has been found to reduce hospitalizations for bleeding or thromboembolism. Another study estimated that there would be substantial cost savings ($604 million) if patients with metastatic colorectal cancer were screened for the KRAS gene prior to beginning treatment. A retrospective analysis of precision medicine outcomes in patients with advanced cancer found improved progression-free survival and lower charges per week for patients who received genomic testing and targeted therapy. Over time, it is anticipated that genetic/genomic services will become more affordable and thus potentially produce greater cost savings. Payment and coverage for genetic/genomic services, which was addressed in the I-17 Joint Report, continues to be a barrier to patient access to precision medicine. While some genetic/genomic tests and therapeutics are covered by insurers, many others are not, and there is substantial variability among public and private insurers with regard to payment and coverage and prior authorization requirements. Coverage may also vary based on the intended use of genetic/genomic testing.

The market shift from a fee-for-service (FFS) to a value-based model should support and encourage the adoption of evidence-based genetic/genomic precision medicine services. However, it is a challenge to design new payment models that aim to improve care for whole populations while implementing precision medicine that is aimed at identifying the correct diagnosis and treatment plan for an individual patient. Stakeholders must engage in ongoing discussions to identify areas where APMs and precision medicine may work together and support one another. If properly designed and incentivized, together APMs and precision medicine have the capacity to yield better care, better health, and lower costs over the long term.

POTENTIAL IMPACT OF APMS ON PRECISION MEDICINE

Precision medicine represents life-altering opportunities and potential. However, policymakers must be diligent to appropriately weigh the balance between quality and cost-savings and, in particular, short term cost-savings. The drive to make genetic/genomic medicine available may be stifled when providers are assessed or penalized for spending, as they are in APMs. Such assessment of providers based on spending may be particularly problematic when that spending yields improvements that cannot be considered in a specific or small window of time. A recent MedPAC report denotes a potential issue with the structure of many APMs being that the paradigm of cost savings in a specific period of time may be appropriate for some services and procedures that have remained unchanged over the course of many years; however, such a structure may not be appropriate for new tests and technologies, especially those that might improve patient quality of life over the course of many years. For example, it may be challenging to align a payment system, such as a bundled payment APM, with the appropriate quality measures. While the use of precision medicine could improve a patient’s quality of life or prevent downstream disease recurrence, it is difficult to identify and promote quality measures that capture the value of such interventions within a specified window. Policymakers must acknowledge such challenges of
implementing precision medicine within the context of APMs so as to realize the potential of
innovative technologies to improve care quality, value, and patient satisfaction.

As medical knowledge of the genome continues to evolve and grow, the number of options and
tools to assist providers in diagnosis and treatment is rapidly expanding. While tens of thousands of
genetic tests are currently available, there is widespread variability in the costs and insurer
coverage of these tests and clinicians may have a difficult time determining the right test for a
given patient. For example, oncology clinical practice guidelines currently recommend more than
30 tumor biomarkers across all cancers to support appropriate treatment and decision-making with
the list of potential biomarkers growing and changing in response to the rapid pace of clinical
research. Genetic tests range from testing for a specific alteration and a specific gene to testing
large genetic panels on many hundreds of genes at the same time. Though guidelines from the
National Comprehensive Cancer Network and other professional groups help direct physicians to
the best genetic tests for a given patient, physicians need the decision support to help determine
which mutations to consider for a specific tumor type and what genetic tests are most appropriate
for a given patient. Studies have suggested that many physicians report being inadequately
prepared to use genetic/genomic information for patient care, while others remain unsure that
genomic information is clinically useful. Education and awareness are needed for successful
implementation of genetic/genomic precision medicine, and tools used by APMs may be able to
help address some of the knowledge gaps.

CLINICAL PATHWAYS AND DECISION SUPPORT TOOLS

Many APMs already create incentives to use care protocols, clinical pathways, and other decision
support tools in treatment decision-making. Pathways act as a decision support tool for physicians
to know the right genetic test to use for each patient based on the nature of the patient’s disease. The pathways then recommend treatments based on the test results. At times these pathways
receive prior authorization from payers, having the effect of expediting the process of getting the
test and treatment to the patient. Yet many providers can have difficulty using the decision support
resources necessary to assess the value of precision medicine when confronted with high upfront
costs of new technologies.

Often clinical pathways produce a single instance of savings after use. However, because pathways
are generally developed based on the broader population, requirements to adhere to clinical
pathways may have the effect of constraining the ability of providers and patient to identify and
choose the patient’s best available treatment options. Therefore, one-size-fits-all pathways and
adherence requirements may result in missed opportunities to tailor treatment based on individual
patient genetics, environment, and lifestyle choices.

Stakeholders are attempting to combat the issue of one-size-fits-all pathways by using data
registries that expand the evidence base of available therapies. The use of data registries and rapid
learning systems can extract clinically relevant data and apply the data to practice guidelines in
real-time. One example of an adjustable pathway model is the Department of Veterans Affairs
(VA) Point-of-Care Precision Oncology Program (POCOP). The POCOP uses electronic health
records (EHRs) and real-time data sharing to integrate knowledge from external sources about
molecular medicine in cancer with experience and information of other veterans in the program
including genomic information from a patient’s tumor and history with prior therapies. Ultimately, the POCOP could guard against simply using short-term lower cost pathways and serve
as a model of rapid data-sharing, creating an evidence base that is continuously updated and can
inform treatment decisions at the point of care.
Similarly, the American Society of Clinical Oncology (ASCO) is developing a rapid learning system by building a cloud-based, big data, health IT platform called CancerLinQ.\(^\text{15}\) CancerLinQ extracts data from EHRs and other data sources and employs data analytics to generate knowledge that is available at the point of care to oncologists and patients. The primary objective of the learning system is to provide real-time feedback to physicians to enable them to deliver personalized insights at the point of care and accelerate new clinical hypotheses and pathways by uncovering patterns in patient and tumor characteristics, therapies, and outcomes. As precision medicine evolves and we gain insight on the role of genetic and other variation in patient response to treatment, clinical pathways and other decision support tools will need to keep pace.

INCORPORATING PRECISION MEDICINE INTO APMS TO IMPROVE DIAGNOSIS

A current barrier in the health care delivery and payment system is a lack of payment for some key aspects of the work associated with obtaining an accurate diagnosis. Current payment structures often do not pay for consultation with other physicians, and patients often face delays in access to care, particularly specialists, which can lead to exacerbations in symptoms and disease progression before a diagnosis is established and a treatment plan is developed. Furthermore, often significant amounts of time are dedicated to ruling out diagnoses rather than establishing an accurate diagnosis. This issue of the diagnostic odyssey is driven in part by the structure of FFS in which payments are made for conducting tests rather than paying for the process of determining what tests to order.

To overcome this barrier, APMs should be encouraged to leverage technology to support the goals of the APM and help physicians improve patient engagement, collaboration, diagnosis, treatment planning, and quality. APMs have the capacity to support more accurate diagnoses and tailored treatment plans, and precision medicine can play an important role in realizing this potential. Not only can APMs support collaborative efforts between various health professionals such as pathologists, radiologists, and others, but also, APMs, with the help of clinical pathways and guidelines, can pay for targeted genetic and genomic tests that support faster and more accurate diagnoses and the development of an individualized treatment plan. It is important to note that genetic/genomic testing provides clinical information beyond diagnostics, including prognosis and therapeutic tailoring. APMs should support new approaches to care delivery, and precision medicine is an important component of achieving more accurate diagnoses.

EXAMPLES OF APMS IMPLEMENTING PRECISION MEDICINE

The Radiation Oncology Alternative Payment Model (RO-APM)

Though the role of precision medicine across health care settings and payment models is still evolving, oncology care illustrates how an APM can help support precision medicine. Specifically, the American Society for Radiation Oncology is developing the RO-APM, which would incentivize the appropriate use of cancer treatments that result in the highest quality of care and best patient outcomes. The RO-APM holds physicians accountable for the spending related to the condition and applies to major disease sites treated with radiation therapy, creating an episode-based payment that begins with clinical treatment planning and concludes 90 days after the last radiation treatment. Throughout the episode, clinicians must adhere to nationally accepted clinical treatment guidelines and other quality improvement requirements.

With the use of genetic/genomic precision medicine, providers can optimize radiation therapy based on a patient’s tumor profile. Its use can shape dosage to minimize side effects and spare healthy tissue. A recent study conducted at the University of North Carolina found that
approximately 20 percent of radiation therapy patients experienced an unplanned hospital admission within 90 days of their treatment. Precision medicine can yield better, more targeted treatment planning to lower the risk of post-radiation therapy toxicities and avoid the need for toxicity-related inpatient visits. An APM can support enhanced patient monitoring and better management of patient care and result in fewer inpatient visits, ultimately decreasing the average cost of care per radiation therapy patient.

**Patient-Centered Oncology Payment**

The ASCO developed the Patient-Centered Oncology Payment (PCOP) model to improve the quality and affordability of cancer care. The model pays practices for services that are not currently billable, including non-face-to-face visits and consultation with other specialists, and imparts practices with the flexibility to tailor services to unique patient needs, which results in the delivery of high-quality, individualized services. The PCOP system is designed to provide supplemental, non-visit-based payments to practices to support accurate diagnosis, treatment planning, and care management. Using PCOP, practices would bill for new patient treatment planning, care management, active monitoring, and participation in clinical trials. In return for PCOP paying adequately for patient services at the outset, practices agree to adhere to appropriate use criteria and other accepted standards of care. Furthermore, practices and payers agree to a robust performance measurement system, so payers are assured that oncology practices are accepting accountability for spending and agreeing to standards of care while focusing on care approaches that have the demonstrated ability to lower costs without harming quality.

**Private Insurer Incorporating Precision Medicine into Value-Based Care**

Harvard Pilgrim Health Care is an example of a private insurer that has taken steps to incorporate precision medicine into a value-based care model. In February 2018, Harvard Pilgrim entered into a contract with the test developer Illumina to broaden eligibility of noninvasive, prenatal genetic testing to pregnant women under age 35 (average risk pregnancies). While the insurer anticipates that savings on other prenatal screenings will offset the costs of the next generation sequencing tests, Illumina has agreed to pay for cost overages. A two-year study will help determine whether expanded availability of noninvasive prenatal genetic testing will affect spending and demonstrate clinical value to patients.

**AMA ACTIVITY**

The AMA continues to work to aid physicians in the implementation of APMs and other components of MACRA. The AMA has conducted educational activities including webinars and regional conferences for physicians and staff and continues these activities. Recent AMA advocacy activity has called for improvements in the methodologies behind APMs to reduce barriers and enable more physicians to participate. The AMA has made extensive comments on all MACRA proposed and final rules and has successfully advocated for a number of changes, including the modification of the definition of financial risk.

AMA advocacy efforts are also focused on the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and Physician-Focused Payment Models (PFPMs). The AMA attends and makes public comments at meetings of the PTAC, submits comments on its draft documents and stakeholder proposals, and works with specialty societies developing PFPM proposals to help address challenges they face in APM design. To that end, the AMA has convened APM workshops to bring together many of the leading physicians who are working on PFPM proposals to discuss potential solutions to these issues.
The AMA is also engaged in ongoing advocacy related to genetic/genomic precision medicine, including oversight of laboratory-developed tests, and implementation of the Protecting Access to Medicare Act which significantly revised the Medicare payment system for laboratory tests, including genetic tests.

**Health IT and Digital Health**

Significant improvements in EHRs and other health IT capabilities are critically needed for precision medicine to reach its potential under the new payment models. Robust and interoperable health IT systems must be able to access and display longitudinal health data from each patient regardless of where the data are stored. EHRs hold biological, behavioral and environmental data; however, impediments to accessing and securely exchanging data across health care systems must be overcome. The AMA actively promotes EHRs that can provide clinical decision support and use genetic/genomic data to provide clinically meaningful information to physicians. The AMA’s Integrated Health Model Initiative supports a continuous learning environment to enable interoperable technology solutions and care models that evolve based on real-world use and feedback.

Beyond EHRs, the AMA is committed to influencing the evolution of health IT and digital health, both of which are integral to the implementation of precision medicine. The AMA provides leadership on digital solutions involving telemedicine and telehealth, mobile health, wearables, and remote monitoring. Using the expertise of physicians and input from partners on the leading edge of health technology, the AMA has developed resources, toolkits and training to help physicians evaluate and optimally use newly available technology for improved care.

Additionally, the AMA continues to educate physicians about the clinical uses of genetic/genomic services. To assist physicians encountering new precision medicine technologies, the AMA has partnered with Scripps Translational Science Institute and The Jackson Laboratory to develop “Precision Medicine for Your Practice,” a series of online continuing medical education modules covering topics such as expanded carrier screening in prenatal care, prenatal cell-free DNA screening, somatic cancer panel testing, large scale sequencing as a diagnostic tool, and pharmacogenomics. The AMA has partnered with the NIH All of Us Research Program, a soon-to-be launched precision medicine initiative to study one million or more Americans. Furthermore, the AMA has conducted surveys to better understand physician awareness and confidence with precision medicine practices. The AMA is also maintaining dialogue with other key stakeholders through activities such as the National Academies of Science, Engineering and Medicine Genomics Roundtable.

**RELEVANT AMA POLICY**

Policy H-385.913 created foundational policy to support the appropriate shift to physician-focused APMs. Policy H-385.913 promulgated goals for physician-focused APMs, developed guidelines for medical societies and physicians to begin identifying and developing APMs, and encouraged CMS and private payers to support provision of assistance to physician practices implementing APMs. The policy has been influential in related AMA advocacy thus far, which has included submission of extensive comments on the MACRA proposed and final rules and responses to draft documents from the PTAC and proposed models from Center for Medicare & Medicaid Innovation. The AMA has a key role in helping physicians develop and participate in APMs.

Building on Policy H-385.913, Policy H-385.908 offers a set of guidelines to address the barriers that interfere with the shift to value-based payment. Such barriers to the development and
implementation of APMs include limitations of existing health IT capabilities, resource use measures, and resource use challenges including risk adjustment, attribution, and performance target-setting.

The AMA has extensive policy related to physician-led payment reform models. AMA policy is committed to promoting physician-led payment reform programs that serve as models for others working to improve patient care and lower costs (Policy D-385.963). Policy H-390.844 emphasizes the importance of physician leadership and accountability to deliver high quality and high value to patients. In transitioning from the sustainable growth rate (SGR), the AMA advocates for providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions (Policy H-390.844). Policy D-390.953 directs the AMA to advocate with CMS and Congress for APMs developed in concert with specialty and state medical organizations. Policy H-450.931 recognizes that physicians will need assistance transitioning to APMs.

Policy H-390.849 directs the AMA to advocate for the adoption of physician payment reforms that promote improved patient access to high-quality and cost-effective care and that such reforms be designed with input from the physician community. It calls for reformed payment rates that are sufficient to maintain a sustainable medical practice and that payment reform implementation should be undertaken within a reasonable timeframe and with adequate assistance.

Policy D-185.980 established foundational policy on payment and coverage for genetic/genomic precision medicine. The policy encourages payers to adopt processes and methodologies for determining coverage and payment for genetic/genomic precision medicine that: promote transparency and clarity; involve multidisciplinary stakeholders; describe the evidence being considered; provide opportunities for comment and review as well as meaningful reconsiderations; and incorporate value assessments that consider the value of genetic/genomic tests and therapeutics to patients, families and society as a whole, including the impact on quality of life and survival. Policy D-185.980 also encourages the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics that have clinical impact, and also encourages national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches.

Policy H-410.948 provides guidance on the development of clinical pathways and supports the development of transparent, collaboratively constructed clinical pathways that are implemented in ways that promote administrative efficiencies for both providers and payers; promote access to evidence-based care for patients; recognize medical variability among patients and individual patient autonomy; promote access to clinical trials; and are continuously updated to reflect the rapid development of new scientific knowledge. Additionally, the AMA has significant and comprehensive policy on health IT. Policy H-450.933 encourages efforts to develop and fund clinical data registries; supports flexibility in the development and implementation of clinical data registries; encourages physicians to participate in clinical data registries; and advocate for and support initiatives that minimize the costs of physician participation in clinical data registries.

DISCUSSION

With MACRA taking effect and precision medicine gaining traction in clinical practice, the Council believes that physicians need to lead the development and integration of these two promising innovations. It is important that the payment and delivery reform movement recognizes the incremental value of precision medicine, especially as more evidence of its effectiveness becomes available. With the emergence of APMs and the drive to value, the AMA is poised to be a
leader in addressing unnecessary care costs and realizing the benefits of APMs, and one of the most valuable ways to maximize value may be through precision medicine, particularly for certain specialties.

The Council believes that clinical pathways provide an opportunity to confront the tension between achieving cost-savings targets and providing better patient care and improving outcomes and recognizes the utility of data registries. To that end, AMA policy on clinical pathways (Policy H-410.948) and data registries (Policy H-450.933) is recommended for reaffirmation. To further ensure that clinical pathways are successful, the Council recommends affirming that they should be developed by clinical experts, including national medical specialty societies, and be leveraged by or integrated into EHRs for decision support, unified documentation, and automation of communication with payers for authorization.

Because expert-driven, evidence-based clinical pathways can help physicians identify genetic/genomic tests and services for patients, the Council recommends encouraging APMs to incorporate them as appropriate and as recommended by national medical specialty societies. The Council further believes that appeal mechanisms should be available to patients and physicians when national medical specialty society-recommended pathways are rejected. The Council also recognizes the potential impact of rapid learning systems on precision medicine and APMs, and recommends supporting transparent and accessible rapid learning systems with the ability to extract clinically meaningful information and use it to modify clinical practice guidelines and pathways in real-time.

For many providers, especially those participating in APMs, it is challenging to use the resources necessary to assess the full clinical and economic value of precision medicine when confronted with high up front cost of new technologies, particularly when the use of new tests or therapeutics may negatively affect a provider’s cost-savings targets. Accordingly, the Council recommends that the AMA support assessment within new payment and delivery models of the value of evidence-based precision medicine tests and therapeutics to patients, families and the health care system, including the impact on patient experience, disease progression, quality of life and survival.

The Council firmly believes that the APM focus on lowering costs must not have the unintended effect of discouraging adoption and use of innovative tests and therapeutics that, though more expensive in the short-term, have the potential to deliver better long-term outcomes for patients. Accordingly, the Council recommends that the AMA encourage APMs to integrate precision medicine approaches, where appropriate, to improve the diagnostic process and personalize patient care.

Finally, the Council recognizes that a key challenge to integrating precision medicine into new payment models is that APMs are generally structured around cost savings within a specified window of time and may not account for improved outcomes downstream. Therefore, the Council recommends that the AMA encourage APMs to consider measuring patient outcomes and quality improvements over time to allow for the use of precision medicine tests and therapeutics that have clinical value.
RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-410.948 supporting the development of transparent, collaboratively constructed clinical pathways that promote administrative efficiencies and access to evidence-based care, recognize variability among patients and individual patient autonomy, promote access to clinical trials, and are continuously updated to reflect new scientific knowledge. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-450.933 encouraging efforts to develop and fund clinical data registries, and supporting flexibility in the development and implementation of clinical data registries. (Reaffirm HOD Policy)

3. That our AMA affirm that clinical pathways should be developed by clinical experts, including national medical specialty societies, and should be leveraged by or integrated into electronic health records for decision support, seamless documentation, and automation of communication with payers for authorization. (New HOD Policy)

4. That our AMA encourage alternative payment models (APMs) to incorporate evidence-based clinical pathways as appropriate and as recommended by national medical specialty societies. (New HOD Policy)

5. That our AMA support transparent and accessible rapid learning systems with the ability to extract clinically meaningful information and use it to modify clinical practice guidelines and pathways in real-time. (New HOD Policy)

6. That our AMA support assessment within new payment and delivery models of the value of evidence-based precision medicine tests and therapeutics to patients, families and the health care system, including the impact on patient experience, disease progression, quality of life and survival. (New HOD Policy)

7. That our AMA encourage APMs to integrate precision medicine approaches, where appropriate, to improve the diagnostic process and personalize patient care. (New HOD Policy)

8. That our AMA encourage APMs to consider measuring patient outcomes and quality improvements over time to allow for the use of precision medicine tests and therapeutics that have clinical value. (New HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


7. supra note 4.


10. Id.


12. supra note 8.

13. supra note 4.

14. Id.


Whereas, The continuing consolidation of healthcare by hospital mergers and practice acquisitions has resulted in the majority of physicians now being employed by corporations and healthcare systems, which leads to physician practice uncertainty and disputes that are likely to grow as career options become more limited; and

Whereas, The past several years have witnessed a shift of the practice of medicine by transforming physicians from clinical decision makers to salaried technicians with a job description that includes data entry, coding/billing, transcribing, medical guideline implementation, and patient care coordination so as to enhance revenue reimbursement for their employer; and

Whereas, Employed physicians have increasingly become merely revenue generators, resulting in individual contract negotiations becoming one-sided under the direction of corporate executives and managers with no leverage for the physicians; and

Whereas, This relationship is modeled after the hotel/hospitality industry standards of short-term occupancy, centralized decision making, customer relations and structured pricing that is then taught in hospital administration programs; and

Whereas, During the period from 1970 to 2016, there has been a doubling of the number of physicians to match the same increase of the population of the United States but a 3000% rise in hospital executives, and a corresponding 2300% increase in healthcare spending per capita; and

Whereas, The increasing need for revenue generation from employed physicians by medical corporate interests has led to the systematic devaluation of medical inquiry, experience, independence and professional growth leading to despondency within the profession of medicine; therefore be it

RESOLVED, That our American Medical Association adopt an “Employed Physician’s Bill of Rights” (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational endeavors and preparation, committee participation, student/resident activities and administrative responsibilities (New HOD Policy); and be it further
RESOLVED, That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physician activities performed outside of defined employed-time boundaries are the sole prerogative of the individual physician and not the employer organization unless it directly conflicts with or increases risk to the organization (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that conflict-of-interest disclosures should be limited to physician activities that directly affect the organization and should only be disclosed to entities that directly reimburse the physician during their employed time period (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act) (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that all physicians be empowered to first be the patient’s advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient’s health care and dignity. (New HOD Policy)

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

Received: 12/04/17
Whereas, A shortage of physicians is present in the U.S.; and

Whereas, Physicians have the longest standard duration of education, representing both significant societal and personal investment; and

Whereas, Physicians have, at different points in their careers, different factors they must consider to maintain a work-life balance; and

Whereas, Currently, about 80 percent of Indiana physicians are employed by non-physician owned hospitals/businesses; and

Whereas, This resolution should also be considered by the Organized Medical Staff Section, which has an interest in the relationship between medical staff and hospital administration; therefore be it

RESOLVED, That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.

2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.

3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.

4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other “greater societal good” organizations.

5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Resolved, That our American Medical Association vigorously oppose clinical credentialing based solely on surgical and non-surgical case volume when there is no other basis for questioning the physician’s ability to function with skill and safety. (New HOD Policy)

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

Received: 04/24/18
Whereas, The Centers for Medicare and Medicaid Services now disallows any claim made if there is any discrepancy in the charted note; and

Whereas, In a review they will use this as evidence of false claims and demand a percentage of the yearly payment made back from the physician; and

Whereas, The patients often give us different answers to questions during different parts of the history which may then seem discordant; and

Whereas, Physicians do use a template format to make the charting less time consuming and to be able to spend more time with the patients face to face; a small error can be made; and

Whereas, We are humans, and humans make mistakes; and

Whereas, A mistake of this nature in no way proves that the physician has not spent time and effort doing the work of a physician for the patient; and

Whereas, This type of measure, although easy for a low level examiner to do, in no way reflects the quality, importance, and appropriateness of the medical care delivered; and

Whereas, This is clearly a ploy to not pay physicians for their work; or at best, delay payment which causes a substantial increase of the cost of doing billing; therefore be it

RESOLVED, That our American Medical Association seek through legislation and/or regulation policies opposing claim nonpayment due to minor wording or clinically insignificant documentation inconsistencies (Directive to Take Action); and be it further

RESOLVED, That our AMA seek through legislation and/or regulation policies opposing extrapolation of overpayments based on minor inconsistencies (Directive to Take Action); and be it further

RESOLVED, That our AMA seek through legislation and/or regulation policies opposing bundled payment denial based on minor wording or clinically insignificant documentation inconsistencies. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Whereas, Federal regulation requires all physicians who do specimen testing to purchase a federal CLIA\(^1\) permit that must be renewed every 2 years; and

Whereas, The same CLIA tests performed in a physician’s office are deemed CLIA-waived tests, the same tests that any consumer may purchase and use without a CLIA permit; and

Whereas, The use of a microscope by a physician is likewise subject to additional payment and regulation as per the CLIA Amendment; therefore be it

RESOLVED, That our American Medical Association adopt the position that it is proper to remove the CLIA certification mandate requirement for physicians who only use CLIA-waived tests and physician-performed microscopy. (New HOD Policy)

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

Received: 04/25/18

RELEVANT AMA POLICY

Clinical Laboratory Improvement Act of 1988 H-260.980

1. It is the policy of the AMA to (a) continue and intensify its efforts to seek appropriate and reasonable modifications in the proposed rules for implementation of the Clinical Laboratory Improvement Amendments (CLIA) 88; (b) communicate to Congress and to the Centers for Medicare & Medicaid Services (CMS) the positive contribution of physician office laboratory testing to high quality, cost effective care so that through administrative revision of the regulations, clarification of Congressional intent and, if necessary, additional legislation, the negative impact of these proposed regulations on patient care and access can be eliminated; (c) continue to work with Congress, CMS, the Commission on Laboratory Assessment, and other medical and laboratory groups for the purposes of making the regulations for physicians’ office laboratories reasonable, based on scientific data, and responsive to the goal of improving access to quality services to patients; (d) protest the reported high costs being considered for certification of laboratories and the limited number of laboratory categories proposed; (e) encourage all components of the federation to express to CMS and members of Congress their concerns about the effect of the proposed rules on access and cost of laboratory services; and (f) protest the very limited list of waived tests.

2. Our AMA will send a letter to CMS stating that CLIA requirements regarding provider-performed microscopy procedures and annual competency assessments are overly burdensome for physicians and their practices.


\(^1\) The Clinical Laboratory Improvement Amendments of 1988 statute is an amendment to the Public Health Services Act of 1967 [Public Law 90-174, Dec 5, 1967] in which Congress revised the federal program for certification and oversight of clinical laboratory testing. Two subsequent amendments were made after 1988. The law continues to be cited as CLIA '88 as named in legislation.

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations include federal standards applicable to all U.S. facilities or sites that test human specimens for health assessment or to diagnose, prevent, or treat disease. CDC, in partnership with CMS and FDA, supports the CLIA program and clinical laboratory quality.

Waived tests include test systems cleared by the FDA for home use and those tests approved for waiver under the CLIA criteria. A list of waived tests can be found at https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCilia/analyticswaived.cfm
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-18)

Introduced by: New York

Subject: Ensuring Medicare Coverage for Long Term Care

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

Whereas, Long term care services are received by over 12 million Americans today, with projections pushing the number to over 27 million in the next 40 years; and

Whereas, Long term care services can quickly exhaust private resources and, as a result, two-thirds of long term care is paid out of state Medicaid programs; and

Whereas, Medicare currently covers 100% of the 20-days of a skilled nursing facility; but on day 21 leaves a daily coinsurance (currently at $167) as the responsibility of the patient’s family, which for many is unaffordable; and

Whereas, Past and current discussions of our healthcare system are silent on long term care; therefore be it

RESOLVED, That our American Medical Association support the concept of increasing the existing 20-day limit of full Medicare coverage for a patient’s skilled nursing facility stay (New HOD Policy); and be it further

RESOLVED, That our AMA work to identify mechanisms by which the additional costs for this care can be fairly covered. (Directive to Take Action)

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

Received: 04/25/18
RELEVANT AMA POLICY

Policy Directions for the Financing of Long-Term Care H-280.991
The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.

WHEREAS, Health insurance is a contract between a health insurance company and a patient; and

WHEREAS, Health insurers and employers have created insurance products with copayments, coinsurance, and increased deductibles to lower premium costs, reduce utilization of unnecessary services, and to transfer costs to patients and physicians; and

WHEREAS, Insurers establish cost sharing via contracts with employers and their insured; and

WHEREAS, According to the Kaiser Family Foundation, between 2004-2014, patient cost sharing rose substantially faster than payment for care by health plans; and

WHEREAS, High deductible health plans have increased dramatically. According to a Commonwealth Fund study, the share of privately insured adults who had a health plan without a deductible fell from 40% in 2003 to 25% in 2014. By 2014, 11% of adults had a deductible of $3,000 or more, up from just 1% in 2003. Plans experienced a 22% increase of enrollment in high deductible plans in 2015 from 2014; and

WHEREAS, EMTALA providers are obligated to provide care without any guarantee that the patient will be able to meet any cost sharing obligations, particularly because there is not an established relationship with the patient. According to CroweHorwath.com hospitals collect significantly less from patients with higher cost-sharing amounts; and

WHEREAS, The shift to more patient cost-sharing means physicians must collect more costs directly from patients and physicians are collecting less. According to an MGMA study, 23% of total patient services revenue is attributed to patient cost-sharing. For patient obligations of $200 or more, a physician collects payment within one year only 66% of the time. An average of 3.33 billing statements were sent before a patient’s outstanding balance was paid in full; and

WHEREAS, Payment for services may be more convenient for patients if the health plan bills the enrollee directly for the total cost-sharing balance; therefore be it

RESOLVED, That our American Medical Association urge health plans and insurers to bear the responsibility of ensuring physicians promptly receive full payment for patient copayments, coinsurance and deductibles. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 05/01/18
RELEVANT AMA POLICY

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans H-165.849

1. Our AMA opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering cash discounts for expedited payment, particularly for patients enrolled in health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other consumer-directed health care plans.

2. Our AMA will engage in a dialogue with health plan representatives (e.g., Americas Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans.

Whereas, Regulations for Medicare admissions to acute care hospitals and inpatient rehabilitation units include arbitrary paperwork and signature deadlines; and

Whereas, An entire rehab stay has been denied by reviewers because a document was signed an hour too late; and

Whereas, An entire acute hospital admission has been denied because a verbal admission order was not signed before discharge; and

Whereas, These arbitrary deadlines are not related to the medical necessity of the admission; and

Whereas, Denials based on time frame of signature are unfair to the patient, physician and hospital as the denial is based on a technical issue, not on true medical necessity of the procedure or admission; therefore be it

RESOLVED, That our American Medical Association work to change admission order signature timeframe regulations at the Centers for Medicare and Medicaid Services to be consistent with timeframe regulations for other verbal and telephone orders. (Directive to Take Action)

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

Received: 05/02/18
Whereas, The prior authorization process for durable medical equipment for power wheelchairs and other equipment has turned into a process based on time frames and arbitrary deadlines rather than medical necessity; and

Whereas, Denials occur when all the appropriate paperwork does not arrive within a specific limit timeframe regardless of whether the paperwork is complete and comprehensive; and

Whereas, Denials based on arbitrary time frames are unfair to patients who desperately need the equipment and physicians who are doing their best to justify the equipment; therefore be it

RESOLVED, That our American Medical Association advocate that denials of prior authorization for durable medical equipment must be based on true medical necessity not arbitrary time limits or other paperwork issues (New HOD Policy); and be it further

RESOLVED, That our AMA continue to work to improve the prior authorization process for Medicare Managed Care Plans. (Directive to Take Action)

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

Received: 05/02/18
Whereas, Health care statistics have shown that the majority of health care dollars are spent for patients in the last six months of their lives; and

Whereas, Implementation of Advance Directives with clear goals of care, including code status, has been shown to reduce these costs, preserve the dignity of the patient, improve patient and family satisfaction, and reduce patient and family anxiety as the end of life nears; and

Whereas, Conversations about Advance Directives and goals of care are reimbursable visits and a quality metric for primary care physicians who often have a longitudinal relationship with the patient and, thus, may be the ideal health care provider to have these difficult conversations with patients; and

Whereas, Repetitive conversations about end-of-life decisions may be emotionally taxing for patients and their families, particularly when the patient may be encountering ill health and may be receiving health care in different settings; and

Whereas, Current Centers for Medicare and Medicaid Services rules require that code status orders be discussed and reordered upon transfer to a skilled nursing facility (subacute rehabilitation facility or long-term care facility) rather than transferring code status orders from the acute care setting or the ambulatory setting; therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to revise or rescind the rules that prevent transfer of code status across the continuum of care in order to better meet the needs of our patients and our health care system in a comprehensive, cohesive, and more cost-effective manner. (Directive to Take Action)

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

Received: 05/02/18
RELEVANT AMA POLICY

Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

Citation: CCB/CLRDPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17;
Whereas, Commercial health insurance companies are increasingly exacting and costly in requiring pre-authorization requests which consume extra-ordinary time of physicians and their office employees; and

Whereas, Medical offices can no longer absorb the costs of these increasingly time-consuming pre-authorization processes; and

Whereas, Many insurers are refusing to approve needed medical care and refusing to provide appeals processes; and

Whereas, A former commercial health insurance company medical director recently admitted under oath that he never looked at patients' records when deciding whether to approve or deny medical care; therefore be it

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services that CPT code 99080 be reimbursed by Medicare. (Directive to Take Action)

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

Received: 05/02/18
Informational Reports

BOT Report(s)
03  2017 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 2017
08  Annual Update on Activities and Progress in Tobacco Control: March 2017 Through February 2018
21  Ownership of Patient Data
32  Studying Healthcare Institutions that Provide Child Care Services
36  Management of Physician and Medical Student Stress
42  Demographic Report of the House of Delegates and AMA Membership

CEJA Opinion(s)
01  Ethical Physician Conduct in the Media

CEJA Report(s)
07  Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report

CLRPD Report(s)
01  A Primer on Artificial and Augmented Intelligence

CME Report(s)
05  Study of Declining Native American Medical Student Enrollment

CMS Report(s)
08  Addressing the Site-of-Service Differential

Report of the Speakers
01  Recommendations for Policy Reconciliation
Subject: 2017 Grants and Donations

Presented by: Gerald E. Harmon, MD, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2017.
## American Medical Association

**Grants & Donations received by AMA**  
**For the Year Ended December 31, 2017**  
**Amounts in thousands**

<table>
<thead>
<tr>
<th>Funding Institution</th>
<th>Project Description</th>
<th>Amount Received</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government Funding</strong></td>
<td></td>
<td>$1,148</td>
</tr>
<tr>
<td>Agency for Healthcare Research &amp; Quality (subcontracted through Northwestern University)</td>
<td>Midwest Small Practice Care Transformation Research Alliance</td>
<td>$299</td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention (subcontracted through National Association of Chronic Disease Directors)</td>
<td>Diabetes Technical Assistance and Support</td>
<td>243</td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention (subcontracted through YMCA)</td>
<td>Diabetes Prevention Program</td>
<td>9</td>
</tr>
<tr>
<td>Centers for Medicare Medicaid Services</td>
<td>Transforming Clinical Practices Initiative — Support and Alignment Networks</td>
<td>453</td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services (subcontracted through Mathematica Policy Research, Inc.)</td>
<td>Quality Measures for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees</td>
<td>53</td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Administration (subcontracted through American Academy of Addiction Psychiatry)</td>
<td>Providers Clinical Support System for Opioid Therapies</td>
<td>91</td>
</tr>
<tr>
<td><strong>Nonprofit Contributors</strong></td>
<td></td>
<td>$998</td>
</tr>
<tr>
<td>American Association of Colleges of Osteopathic Medicine</td>
<td>Accelerating Change in Medical Education Initiative</td>
<td>13</td>
</tr>
<tr>
<td>American College of Physicians</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>10</td>
</tr>
<tr>
<td>American Medical Association Foundation via contributions from Eli Lilly and Company</td>
<td>Accelerating Change in Medical Education Conference</td>
<td>9</td>
</tr>
<tr>
<td>American Medical Association Foundation via contributions from Genentech, Inc.</td>
<td>Accelerating Change in Medical Education Conference</td>
<td>45</td>
</tr>
<tr>
<td>American Medical Association Foundation via contributions from Pfizer, Inc.</td>
<td>Accelerating Change in Medical Education Conference</td>
<td>23</td>
</tr>
<tr>
<td>American Medical Association Foundation via contributions from The Physicians Foundation</td>
<td>Joy in Medicine Research Summit</td>
<td>57</td>
</tr>
<tr>
<td>American Osteopathic Association</td>
<td>Accelerating Change in Medical Education Initiative</td>
<td>13</td>
</tr>
<tr>
<td>Public Library of Science</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>10</td>
</tr>
<tr>
<td>Stanford University</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>30</td>
</tr>
<tr>
<td>The Marcus Foundation, Inc.</td>
<td>Evaluation of a Virtual Interactive Platform in Enhancing Diagnostic Reasoning and Improving Diagnostic Accuracy</td>
<td>788</td>
</tr>
<tr>
<td><strong>Other Contributors</strong></td>
<td></td>
<td>$70</td>
</tr>
<tr>
<td>BioMed Central</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>10</td>
</tr>
<tr>
<td>Copyright Clearance Center, Inc.</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>5</td>
</tr>
<tr>
<td>Precision Computer Works, Inc.</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>5</td>
</tr>
<tr>
<td>Silverchair Science + Communications, Inc.</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>10</td>
</tr>
<tr>
<td>Wolters Kluwer Health</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>30</td>
</tr>
<tr>
<td>Contributions less than $5,000</td>
<td>International Congress On Peer Review and Scientific Publication</td>
<td>2</td>
</tr>
<tr>
<td>Contributions less than $5,000</td>
<td>International Medical Graduates Section Reception</td>
<td>8</td>
</tr>
</tbody>
</table>

**Total Grants and Donations** $2,216
REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-A-18

Subject: Update on Corporate Relationships

Presented by: Gerald E. Harmon, MD, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2017. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

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

YEAR 2017 RESULTS

In 2017, forty-four new activities were considered and approved through the corporate review process. Of the forty-four projects recommended for approval, thirteen were conferences or events, nine were education, content or grants, nineteen were collaborations or affiliations, and three were member service provider programs (Appendix B).

CONCLUSION

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

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions Group (HSG), Advocacy, Federation Relations, Office of the General Counsel, Medical Education, Publishing, Ethics, Enterprise Communications and Marketing (ECM), Physician Engagement (PE), and Health and Science.

The CRT evaluates each project with the following criteria:

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

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

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.

- AMA sponsorship of external events.

- Independent and company-sponsored foundation supported projects.

- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA’s name, logo, and trademarks. This does not include database or CPT licensing.)

- Member service provider programs such as new affinity or insurance programs and member benefits.

- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.

- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.

- Collaboration with academic institutions only if there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.
In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

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

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

**SUMMARY OF CORPORATE REVIEW**

**RECOMMENDATIONS FOR 2017**

<table>
<thead>
<tr>
<th>Project No.</th>
<th>Project Description</th>
<th>Corporations</th>
<th>Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>27797</td>
<td>Sandy Hook Promise Gala – Continue AMA sponsorship, name and logo use for the June 2017 event.</td>
<td>Sandy Hook Promise, The Sorenson Family, Standard and Poor (S&amp;P) Global, Inc., Verizon Wireless, Mehlman Castagnetti Rosen &amp; Thomas, Akin Gump Straus Hauer &amp; Feld, LLP, American Health Care Association (AHCA), Discovery Communications, Inc., Bank of America, Lockheed Martin Corporation, Anthem, Inc., Association for Accessible Medicines (AAM), American Telephone &amp; Telegraph, Inc. (AT&amp;T), General Dynamics Corporation, CVS Health, PepsiCo, Inc., Lumina Foundation, Genentech, Inc. (A Member of the Roche Group), Comcast Corporation, Blue Cross / Blue Shield Association Pharmaceutical Research and Manufacturers of America (PhRMA), Amalgamated Band, Pacific Gas &amp; Electric Company (PG&amp;E), National Association of Broadcasters (NAB), Aetna Inc., Liberty Partners Group, LLC, Managed Funds Association (MFA)</td>
<td>5/10/2017</td>
</tr>
<tr>
<td>Code</td>
<td>Event Name</td>
<td>Sponsorship Details</td>
<td>Date</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>27981</td>
<td><em>Alliance for Health Policy Dinner</em> – Repeating AMA sponsorship for 2017 event to support advocacy.</td>
<td>8/4/2017</td>
<td></td>
</tr>
<tr>
<td>28216</td>
<td><em>Bellin Health Training Days</em> – AMA sponsorship, name and logo use for Bellin Health conference for their nine step practice transformation framework.</td>
<td>6/22/2017</td>
<td></td>
</tr>
<tr>
<td>28451</td>
<td><em>National Quality Forum (NQF) Annual Conference Sponsorship</em> – Continue AMA sponsorship, name and logo use for NQF Annual Conference “Fulfilling The Quality Mandate.”</td>
<td>11/21/2017</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Event Description</td>
<td>Sponsorship</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 29117 | **American Conference on Physician Health (ACPH)** – AMA name and logo association with Stanford University and the Mayo Clinic for conference on physician well-being. | Stanford University  
Mayo Clinic  
The Physician Foundation  
Coalition for Physician Well-Being |
Eli Lilly  
Elsevier  
Pfizer  
Genentech, Inc. (A Member of the Roche Group) |
| 29472 | **2017 Sling Health Demo Day** – AMA sponsoring national Sling Health Demo Day. | Sling Health  
Bank of America  
St. Louis Bioscience (BioSTL)  
St. Louis Cardinals  
Community Development Ventures, Inc.  
Entrepreneur’s Organization  
iSelect  
Pharmaceutical Research and Manufacturers of America (PhRMA)  
St. Louis Local Businesses (Randall’s, Sameem’s, Schlafly, Urban Chestnut)  
St. Louis Metropolitan Medical Society |
| 29797 | **Reach Media Collaboration** – AMA Improving Health Outcomes (IHO) sponsorship of the Tom Joyner Family Reunion and Take a Loved One to the Doctor Day events. | Read Media Limited  
Community Health of South Florida, Inc. |
| 29835 | **2017 Health 2.0 Annual Fall Conference** – AMA name, logo and sponsorship for physician burnout workshop. | Health 2.0  
TracendInsights  
Cigna Health Insurance  
United Healthcare Services, Inc.  
Allscripts Developer Program  
Datica Health, Inc.  
Nordic Innovation House  
California Health Care Foundation  
Zynx Health Incorporated  
dotHealth, LLC |

AMA / AHIMA Clinical Documentation Improvement (CDI) Outpatient Workshop – AMA and AHIMA co-sponsoring a one day workshop on CDI.

2017 Forbes Healthcare Summit – AMA name, logo and sponsorship to highlight opioid epidemic and showcase new AMA initiatives.

2018 National Rx Drug Abuse & Heroin Summit – AMA name and logo use as event supporter.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Name/Institution</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>29414</td>
<td>Teaching EMR – AMA name and logo use on Regenstrief Teaching EMR website and materials as acknowledgement of AMA’s Accelerating Change in Medical Education grant support.</td>
<td>The Regenstrief Institute</td>
<td>4/6/2017</td>
</tr>
<tr>
<td>29570</td>
<td>Evaluation of Interactive Virtual Technology in Teaching (i-Human Platform) – A controlled AMA research study to evaluate the effectiveness of interactive technology, assess diagnostic reason and improve accuracy utilizing the i-Human platform and funding from the Marcus Foundation.</td>
<td>The Marcus Foundation i-Human Patients, Inc.</td>
<td>5/4/2017</td>
</tr>
<tr>
<td>29749</td>
<td>Sling Health – Chapter Expansion Grants – An AMA grant, name and logo association with Sling Health for student chapter expansion and community on AMA Physician Network.</td>
<td>Sling Health</td>
<td>6/6/2017</td>
</tr>
<tr>
<td>29866</td>
<td>Support for Human Diagnosis Project’s Uninsured Digital Physician Consult Program – The AMA support for MacArthur grant process.</td>
<td>Human Diagnosis Project MacArthur Foundation American College of Physicians</td>
<td>7/7/2017</td>
</tr>
<tr>
<td>30190</td>
<td>Content Collaboration with Ingenious Med – AMA name and logo association with AMA content on Ingenious Med website.</td>
<td>Ingenious Med</td>
<td>9/12/2017</td>
</tr>
<tr>
<td>Code</td>
<td>COLLABORATIONS/AFFILIATIONS</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>30492</td>
<td><strong>AMA and The Atlantic: Custom Content Digital Platform</strong> – AMA developed content for use</td>
<td>10/16/2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>in an AMA / The Atlantic co-branded platform.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30540</td>
<td><strong>Collaboration with Gaples Institute</strong> – Integrative Cardiology nutrition curriculum for AMA Education Center.</td>
<td>10/24/2017</td>
<td></td>
</tr>
<tr>
<td>30804</td>
<td><strong>AMA-AAAPL Physician Leadership Education Curriculum</strong> – Physician Satisfaction and Practice Sustainability (PS2) and the AMA Education Center in partnership with the American Academy of Physician Leadership (AAPL) to develop co-branded physician leadership curriculum.</td>
<td>11/21/2017</td>
<td></td>
</tr>
<tr>
<td>25556</td>
<td><strong>Addition of American Stroke Association to the Target: BP Initiative</strong> – Addition of American Stroke Association to previously approved AMA Improving Health Outcomes (IHO), and American Heart Association, Target: BP program.</td>
<td>7/21/2017</td>
<td></td>
</tr>
<tr>
<td>27962</td>
<td><strong>Collaborative Study on Opioid Prescribing Activity with Premier Inc.</strong> – Premier / AMA collaboration, name and logo association on research designed to reduce opioid-related harms.</td>
<td>10/12/2017</td>
<td></td>
</tr>
<tr>
<td>Project ID</td>
<td>Description</td>
<td>Organization/Partner</td>
<td>Start Date</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>------------</td>
</tr>
<tr>
<td>28930</td>
<td><strong>AMA Collaboration with Samsung SHealth</strong> – AMA to grant Samsung a non-exclusive, royalty free license to display AMA IHO diabetes resources in the Samsung SHealth phone application for U.S. users.</td>
<td>Samsung</td>
<td>9/15/2017</td>
</tr>
<tr>
<td>28964</td>
<td><strong>AMA Physician Opportunities Portal (POP)</strong> – Organization name and logo association with AMA POP interactive tool to identify extra clinical opportunities.</td>
<td>National Court Appointed Special Advocates (CASA) Association</td>
<td>4/17/2017</td>
</tr>
<tr>
<td>29341</td>
<td><strong>AMA / KPMG Co-branded MACRA Survey</strong> – A survey to gather physician feedback on the start of the MACRA Quality Payment Program.</td>
<td>Klynveld Peat Marwick Goerdeler (KPMG)</td>
<td>3/7/2017</td>
</tr>
<tr>
<td>29414</td>
<td><strong>AMA / Accenture Co-branded Cybersecurity Research</strong> – A physician survey on cybersecurity and HIPAA compliance.</td>
<td>Accenture</td>
<td>3/23/2017</td>
</tr>
<tr>
<td>29520</td>
<td><strong>Health Affairs Precision Health Sponsorship</strong> – Co-sponsorship of a “precision medicine” theme issue of the <em>Health Affairs</em> journal.</td>
<td>The Robert Wood Johnson Foundation Precision Health Economics, Illumina, Pharmaceutical Research and Manufacturers of America (PhRMA), Genentech, Inc. (A Member of the Roche Group), Patients Center Outcomes Research Institute (PCORI)</td>
<td>4/19/2017</td>
</tr>
<tr>
<td>29723</td>
<td><strong>AMA Collaboration with Pew and Medstar on EHR Best Practices</strong> – Conduct research and publish report to improve usability and safety of EHRs.</td>
<td>PEW Charitable Trusts, MedStar Health Research Institute</td>
<td>6/27/2017</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Partners/Institutions</td>
<td>Date</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>29760</td>
<td><strong>Center for Healthcare Innovation Sponsorship</strong> – The AMA name and logo to be used on the website and program collateral for The 7th annual Diversity, Inclusion, &amp; Life Sciences Symposium.</td>
<td>Center for Healthcare Innovation National Biotechnology and Pharmaceutical Association National Hispanic Life Sciences Society Women in Healthcare and Life Sciences Gilead Sciences, Inc. Drinker, Biddle &amp; Reath, LLP. Merrill Lynch Northwestern Medicine Robert H. Lurie Comprehensive Cancer Center Aurora Health Care Bridge Clinical Research and Chiltern</td>
<td>6/9/2017</td>
</tr>
<tr>
<td>29929</td>
<td><strong>Partners HealthCare Digital Health Provider Adoption Study</strong> – AMA collaboration and logo use for Partners HealthCare research study to improve clinical adoption of digital health solutions.</td>
<td>Partners HealthCare System, Inc. (PHS)</td>
<td>7/21/2017</td>
</tr>
<tr>
<td>29985</td>
<td><strong>Human Diagnosis Project Alliance</strong> – AMA name and logo association with Alliance to address gaps in specialty care for the underserved.</td>
<td>Human Diagnosis Project The American Board of Internal Medicine (ABIM) The American Board of Specialties (ABMS) The Association of American Medical Colleges (AAMC) The Association of Clinicians for the Underserved (ACU) National Association of Community Health Centers (NACHC) The Dartmouth Institute for Health Policy and Clinical Practice MIT Computer Science &amp; Artificial Intelligence Lab (CSAIL)</td>
<td>8/1/2017</td>
</tr>
<tr>
<td>30105</td>
<td><strong>2017 TEDMED Collaboration</strong> – Recognition as TEDMED global partner for the AMA.</td>
<td>TEDMED</td>
<td>8/23/2017</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
<td>Collaborators</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>9/15/2017</td>
<td><strong>Lucro Collaboration</strong> – To improve digital health solutions through integration of AMA guidelines and solutions into Lucro’s healthcare marketplace platform.</td>
<td>Lucro Global, LLC</td>
<td></td>
</tr>
<tr>
<td>9/22/2017</td>
<td><strong>AMA / HITRUST Collaboration</strong> – Workshop on cybersecurity frameworks for small physician practices.</td>
<td>Health Information Trust Alliance (HITRUST), Binder Dijker Otte (BDO) Global</td>
<td></td>
</tr>
</tbody>
</table>
Integrated Health Model Initiative (IHMI) Collaborators
– AMA name and logo association with external companies as supporters of the IHMI digital platform.

International Business Machines (IBM)
PROMetheus Research
Apervita
Cerner
CareCloud
American Heart Association (AHA)
Patient-Centered Outcomes Research Institute (PCORI)
Private Company Price Index (PCPI)
NEST Coordinating Center (NESTcc)
American Diabetes Association (ADA)
Patients Like Me
American Medical Informatics Association (AMIA)
Snomed
CareMore
The Geisinger Health System (GHS)
Bioreference Laboratories
Clinical Architecture
M*Modal
Optum360
Intermountain Healthcare
Partners Healthcare
University of California San Francisco (UCSF)
American Society of Anesthesiology (ASA)
American College of Cardiology (ACC)
American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American Academy of Allergy, Asthma, & Immunology (AAAAI)
American College of Physicians (ACP)
American College of Surgeons (ACS)
Epic
Qualcomm Life
Medstro
Omada
Healthcare Trust of America (HTA)
Minnesota Mining and Manufacturing (3M)
Partners Healthcare
Kaiser Permanente
HumanDx
Apple
Samsung
Google
Logical Observation Identifiers Names and Codes (LOINC)
United Healthcare
UC Health

30451 Rand Payment Model Study – AMA name and logo on co-branded study book. Study entitled, “Effects of health care payment models on physician practice in the United States.”

30493 HIMSS Annual Conference Collaboration – Continuing AMA participation and logo use for HIMSS annual conference.

30576 Collaborative Study on Antibiotic Stewardship with The Pew Charitable Trusts – Pew / AMA name and logo use on research to assess prescribing practices and the need for antibiotic stewardship in outpatient healthcare settings.

MEMBER SERVICE PROVIDER PROGRAMS

AMA Insurance Agency

AMA Insurance Agency
Subject: Redefining AMA’s Position on ACA and Healthcare Reform

Presented by: Gerald E. Harmon, MD, Chair

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

EFFORTS TO REPEAL THE ACA

Beginning prior to the introduction on March 7, 2017 of the component parts of what would become the American Health Care Act through the Senate’s failure to adopt the so-called “skinny bill” in the early morning hours of July 28, 2017, the AMA consistently engaged with policy makers in support of AMA policies related to the Affordable Care Act. While acknowledging that improvements were needed in the ACA, the AMA opposed repeal on the basis of several policy points adopted by the House of Delegates. Specifically:

• Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans;
• Maintain key insurance market reforms, such as pre-existing conditions, guaranteed issue and parental coverage for young adults;
• Stabilize and strengthen the individual insurance market;
• Ensure that low/moderate income patients are able to secure affordable and meaningful coverage;
• Ensure that Medicaid, The Children’s Health Insurance Program (CHIP) and other safety net programs are adequately funded;
• Reduce regulatory burdens that detract from patient care and increase costs;
• Provide greater cost transparency throughout the health care system;
• Incorporate common sense medical liability reforms; and
• Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends.

A number of factors played into the inability of Congress to advance repeal of the ACA, including the decision to act under the limitations imposed by the budget reconciliation process and efforts to go beyond ACA reform to include significantly restructuring the financing of the Medicaid program without hearings or stakeholder input. Ideological differences among Republican members of Congress and discomfort with projections of significant increases in the number of Americans without health insurance as a result of Congressional action further compromised the pathway to repeal.
Following the failure to repeal ACA as a whole or in part, Congress was expected to turn to efforts
to stabilize the current system in the short term through continuing Cost-Sharing Reduction (CSR)
payments to health plans and reinsurance. However, despite bipartisan efforts to reach agreement,
opting not to strengthen the ACA marketplaces had been brought to the floor for a vote. On October
12, 2017, President Trump announced that we would end CSR payments, which had continued to
be made during pending litigation on their legality. On the same day, the President signed an
Executive Order directing relevant agencies to explore options for more people to buy health
insurance that is exempt from many of the ACA’s requirements.

As a result of the Executive Order, the Administration has released two proposed rules. The first,
released January 4, 2018, would allow more flexibility to groups and small businesses to join
together in an association health plan (AHP). While the AMA supports efforts to maximize health
plan choices for individuals and small businesses, the policy of the House of Delegates also calls
on the AMA to work with federal legislators to ensure that AHP programs safeguard state and
federal patient protection laws. In comments to the Department of Labor (DOL) on the proposal,
the AMA urged DOL to withdraw the proposed rule and work with state insurance commissioners
and health care stakeholders to seek a solution that would expand affordable insurance coverage
options through AHPs without undermining state authority to regulate AHPs to protect patients and
physicians against such things as fraud and insurer solvency. AMA expressed concern that “DOL’s
proposal does not maintain key consumer protections and does not meet the AMA’s key principles
on health system reform … and would result in substandard health insurance coverage.”

The AMA also warned that without proper oversight to account for insololvency and fraud, AHPs
have the potential to increase already high insurance premiums and overall health care costs, while
threatening patients’ health and financial security and the financial stability of physician practices
and made recommendations to address those concerns.

On February 20, 2018, the Administration released a second proposed rule in keeping with the
Executive Order, this time to make it easier for individuals to buy health plans that do not comply
with ACA coverage requirements. The proposal would extend the time that consumers may be
covered by short-term, limited duration health plans that are not required to comply with coverage
requirements from three months to 364 days. These plans may not provide coverage for pre-
existing conditions and benefits such as maternity care and mental health care are often excluded.
Critics have charged that the proposal would fracture the individual market, though administration
officials have disagreed with that assessment. At this writing, the AMA is reviewing the proposal.

Throughout the autumn of 2017, Congress also turned its attention to tax reform. While many in
Congress had considered the possibility of using tax reform to repeal portions of the ACA, such as
the requirement to obtain coverage, to take advantage of the protections from filibuster afforded it
by the Reconciliation process, others expressed serious reservations. Many thought that including
efforts to undermine ACA would erode support for the tax legislation. On November 8, 2017, the
Congressional Budget Office (CBO) released an estimate that repeal of the individual mandate
would result in 13 million fewer individuals having health coverage and premiums increasing an
average of 10 percent. However, CBO also predicted that repeal would produce $338 billion in
budgetary savings over 10 years, savings which could be used to offset some of the deficits
produced by the growing tax cut proposal. On November 16, 2017, the Tax Cuts and Jobs Act bill
passed the House by a vote of 227-205. The Senate followed on December 2, 2017 on a vote of 51-
49. On December 19, the reconciled version of the Tax Cuts and Jobs Act passed both chambers
and was signed into law by President Trump December 22, 2017. The new law eliminates the
penalty for failure to obtain coverage repealing the individual mandate beginning in 2019.
REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-
PERFORMANCE

Our AMA continues to work with Congress and the Administration on the implementation of and improvements to the Quality Payment Program (QPP) established by the Medicare Access and CHIP Reauthorization Act (MACRA). Considerable progress was made in this regard through multiple provisions of the Bipartisan Budget Act of 2018.

On February 9, 2018, the President signed the Bipartisan Budget Act of 2018. The budget bill accomplished a number of critical Congressional priorities, including enacting continuing appropriations through March 22 and setting spending caps for fiscal years 2018 and 2019, suspending the debt ceiling for approximately one year, providing badly needed disaster relief (including increased Medicaid spending for Puerto Rico and the U.S. Virgin Islands as called for by the AMA House of Delegates), extending CHIP reauthorization for an additional four years (through 2027) and addressing the so-called Medicare extenders, including repealing Medicare outpatient therapy caps.

As a result of the work of our AMA and numerous state and national specialty medical associations, a number of improvements to the QPP program were included in the final bill. These included additional flexibility on the establishment of performance thresholds and the application of cost measures, both of which will allow the Centers for Medicare & Medicaid Services to continue to work with the physician community on implementation issues rather than having to proceed immediately to more stringent requirements. Provisions of MACRA that applied the Merit-based Incentive Payment System (MIPS) payment adjustments to Part B drugs were also repealed and the authority of the Physician-focused Payment Model Technical Advisory Committee (PTAC) to provide technical assistance to physicians developing alternative payment models was clarified and broadened. Additionally, the requirement that the Advancing Care Information requirements for physicians under MIPS become more stringent each year was repealed.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Bipartisan Budget Act of 2018 also repealed the IPAB which had been put into place by the ACA. Prior to its repeal, no appointments had ever been made to IPAB and the requirement for recommendations for Medicare cuts by the board was never triggered.

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

While the AMA continues to support efforts to expand access to health savings accounts and expand the use of flexible spending accounts, including support of the “Restoring Access to Medication Act,” no new developments have occurred since the last meeting of the HOD.

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

STEPS TO LOWER HEALTH CARE COSTS

Policymakers continue to explore legislative and regulatory options to reduce the cost of care, particularly as it relates to the costs of pharmaceuticals. While dozens of bills have been introduced and multiple Congressional hearings have been held, no action on these proposals has been
scheduled to date. Our AMA continues to engage physicians and the public through www.TruthinRX.org, including collecting patient stories.

On February 28, 2018, a bipartisan group of U.S. Senators, including Sen. Bill Cassidy, MD, (R-LA) wrote to the AMA and other health care stakeholders regarding their efforts “to increase health care price and information transparency to empower patients, improve the quality of health care, and lower health care costs.” The letter requests stakeholder views on currently available information, what is not available, different methods to achieve price transparency, and other “common-sense” policies to empower patients and lower health care costs. Our AMA will respond to the inquiry and looks forward to engaging with these Senators and others on ways to lower health care costs.

One way to lower costs that is not in dispute is to lower the tremendous amount of time, effort, and resources that go into complying with overly burdensome, duplicative, and unnecessary administrative and regulatory requirements that do not benefit patient care. Physicians and other providers are spending more and more time on paperwork and less time directly on patient care, driving up costs for everyone. Since last summer, the House Committee on Ways and Means has been collecting information from health care providers as part of its Medicare Red Tape Relief Project. In announcing the efforts, Ways and Means Chairman Kevin Brady (R-TX) stated “we will be doing outreach to health care providers, doctors, nurses, hospitals, clinicians on what red tape and regulation out of Washington is interfering with the doctor-patient relationship, driving up the cost of health care, or simply getting in the way of the highest quality health care possible. And so Chairman Tiberi is going to be the one leading that effort. It will include soliciting ideas on what the Administration and executive branch can do, as well, and ultimately leading – we hope – to some action legislatively, as well.” While Subcommittee Chairman Tiberi has left Congress, we are pleased that the new Subcommittee Chairman, Peter Roskam (R-IL), has taken up this mantle, and we will continue to work with him and the committee to identify regulatory changes that can reduce the burden of providing care to Medicare beneficiaries as well as lower health care costs for all.

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

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

CONCLUSION

While much of the federal activity since the 2017 Interim Meeting of the House of Delegates has centered on tax cuts and budgetary issues, health care is never far from the center of the debate. As we have over the last several months, our AMA will continue to seek opportunities to advance the policies that are the subject of this report as well as others adopted by the HOD.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-A-18

Subject: AMA Performance, Activities and Status in 2017

Presented by: Gerald E. Harmon, MD, Chair

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

INTRODUCTION

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

Creating Thriving Physician Practices: Tools For The Field

PS2 Research: The AMA and KPMG surveyed 1,000 practicing physicians in the U.S. who had some awareness of the Medicare and Chip Reauthorization Act of 2015 (MACRA) and are involved in practice decisions related to the Quality Payment Program (QPP). This research aimed to better understand physician preparation and positioning for the QPP in 2017, which was the first reporting year under the program. Key findings of this research have helped the AMA develop educational and training resources for physicians, and have helped carve a path forward for practices participating or planning to participate in alternative payment models and the Merit-based Incentive Payment System (MIPS) through the QPP. The findings of this research were published in June 2017.

In a special report co-authored by senior AMA staff and published in The New England Journal of Medicine, relevant policy trends were identified and key recommendations made to grow the body of evidence on telehealth care delivery. This will have the potential to accelerate telehealth adoption, allowing physicians to enhance their delivery of clinical care.

Digital Health: The AMA formally launched the AMA Physician Innovation Network. Since launch in October, more than 2,070 users (companies and physicians) have joined the site. More than 1,100 of the users are physicians. There have been 1,000+ connection requests sent through the site, approximately 100 opportunities created thus far and numerous collaborators that have signed on to cross promote our efforts (e.g., MATTER, TMCx, Healthbox, and the Society of Physician Entrepreneurs).

More than 1.7 million clinical documents were shared in October 2017 among health care organizations through the Carequality Interoperability Framework. The rate of exchange has been rapidly accelerating each month as 2 million documents were exchanged in total for the first 12
With existing users continuing to onboard clients, and more than a half dozen users expected to go live in the first quarter of 2018, there will be continued growth.

Xcertia, an mHealth app collaborative effort pioneered by the AMA, the American Heart Association (AHA), the DHX Group, and the Healthcare Information and Management Systems Society (HIMSS), builds on each organization’s ongoing efforts to foster safe, effective, and reputable health technologies. Initial content for Xcertia has been completed covering four areas: operability, security, privacy, and clinical evidence, and was released for public comment. The feedback will inform where to focus 2018 work group efforts.

**Physician Payment and Quality:** The AMA is working diligently so that practicing physicians are integral partners in the movement toward a thriving value-based health care system. AMA has created resources and tools for physicians and practice leaders that provide strategic guidance and education, implementation and decision support, and practice financial forecasting, among others. By providing doctors with tools such as the AMA MIPS Action Plan ([https://apps.ama-assn.org/pme/#/actionplan](https://apps.ama-assn.org/pme/#/actionplan)), we assisted physician decision-making and participation in Medicare’s QPP, and in their making the larger move to value-based reimbursement.

**Practice Transformation:** The Professional Satisfaction and Sustainability unit’s (PS2) efforts in measuring physician burnout expanded with the addition of residency programs. We have worked closely with our partners in adapting the Mini-Z to measure burnout amongst residents and fellows. PS2 partnered with AMA Membership in designing and piloting this tool. We confirmed burnout assessments with 11 residency programs across the country. This is an excellent opportunity to further understand the resident and fellow experience, as well as opportunities to identify solutions to enhance the practice of medicine for the next generation of clinicians.

The AMA developed seven new modules in 2017 for STEPS Forward™:
- Creating the organizational foundation for Joy in Medicine
- Adopting OpenNotes: Partnering with patients
- Adult vaccinations: Team-based immunization
- Building a patient experience program
- EHR in-basket restructuring for improved efficiency
- Embedding pharmacists into the practice
- Managing type 2 diabetes: A team-based approach

**Guiding Professional Development: A Commitment To Physician Growth**

In collaboration with IHO, the ACE consortium created and piloted educational programing within the chronic disease prevention and management curriculum at four medical schools. The consortium, also in conjunction with IHO, developed a unique history and physical tool emphasizing biopsychosocial factors. This tool is being piloted at two medical schools.

Osteopathic residencies are now being accredited by ACGME, and staffers have been rapidly adding these newly accredited residencies to FREIDA Online, the AMA Residency & Fellowship Database. Searches for osteopathic residencies increased 95 percent in 2017 compared to 2016. There are now 455 programs on FREIDA that have osteopathic recognition or are formerly American Osteopathic Association accredited programs.
The Regenstrief EHR Clinical Learning Platform, an EHR specifically created for educational settings by Indiana University School of Medicine and the Regenstrief Institute with financial support from the ACE consortium, launched and is now used by five schools.

Innovations emerging from the ACE consortium continued to spread. Health systems science is increasingly recognized as the third pillar of medical education and taught alongside the other two pillars, basic and clinical science. The *Health Systems Science* textbook, published by Elsevier in December 2016, sold thousands of copies around the world and was adopted by 12 schools across the United States.

**Chronic Care: Improving Health Outcomes**

The AMA and American Heart Association launched a national “Health Care Provider High Blood Pressure Education” campaign that has garnered more than 500K acts of engagement via our various platforms. These platforms include Target: BP, a web platform that offers physician practices and health systems access to the new Target: BP Improvement Program (based on the 2017 Hypertension Guideline), which includes self-measured blood pressure as a key component to drive improved health outcomes.

In the fourth quarter of 2017 IHO co-led the successful launch of a new “National High Blood Pressure Awareness Consumer” campaign in collaboration with the AHA and the Ad Council that has already yielded more than 400K visitors to the campaign website (loweryourhbp.org) and garnered $747M in donated media placements across the country.

To date IHO is actively engaged with 11 state medical societies that will serve as models to help scale type 2 diabetes efforts nationwide. The list of states includes:

- Maryland State Medical Society
- Pennsylvania Medical Society
- Mississippi State Medical Association
- Nebraska Medical Association
- Ohio State Medical Association
- Oregon Medical Association
- Massachusetts Medical Society
- Minnesota Medical Association
- Michigan State Medical Society
- South Carolina State Medical Association
- Medical Society of the State of New York

The AMA and American Diabetes Association (ADA) collaborated with Samsung, one of the world’s leading electronics companies, to create a first-of-its-kind “mobile public awareness experience” during National Diabetes Awareness month in November 2017. Aimed at type 2 diabetes prevention, the goal of the collaboration was to help increase awareness among U.S. adults ages 18 to 60 about prediabetes as a condition, and to drive more individuals within this target population to assess their prediabetes risk via Samsung’s “S-Health App” for monitoring physical and other health activities. During the month more than 340K adults completed the prediabetes risk assessment. Our public awareness campaign with the Ad Council, CDC and ADA through television, radio, and print has to date yielded another 560,000 risk test completions.
Advocacy

The AMA took a leading role in the successful fight to preserve access to affordable health care coverage for millions of Americans. Through our site patientsbeforepolitics.org, the AMA generated more than 7 million actions, including calls, emails, and social interactions that helped shape the debate on Capitol Hill.

The AMA blocked two insurance mega-mergers that effectively protected over $500 million in annual physicians’ payments. The U.S. Court of Appeals in Washington, D.C., upheld the lower court’s decision to block the Anthem-Cigna merger. The AMA filed an amicus brief in that case, in which the AMA argued (among many other key points) that the trial court properly found that Anthem's reimbursement cuts, rather than enhancing consumer welfare, could cause quality to degrade and consumers to be deprived of choice. Also, at the AMA’s suggestion, the nation’s experts on antitrust and competition submitted their own amicus brief that supported AMA’s contention. On May 12, 2017, Anthem abandoned the Cigna merger.

The AMA secured retroactive changes to the Medicare legacy reporting requirements that will help physicians avoid $22 million in penalties in 2018, and addressed the biggest regulatory and administrative hurdles for physicians, including prior authorization, electronic health records, and insurer payment practices, such as new federal guidance that stops hidden transaction fees that could cost physician practices thousands of dollars per year.

The AMA secured more than 130 state legislative and regulatory victories on issues related to halting unfair health insurer practices, reversing the opioid epidemic, promoting medical liability reform, protecting Medicaid, and promoting team-based care/opposing inappropriate scope of practice expansions by non-physicians, as well as secured coverage for the Medicare Diabetes Prevention Program and for remote patient monitoring.

Health and Science

The AMA made progress on reversing the opioid epidemic. In 2017 the AMA was able to report fewer opioids being prescribed and an increase in prescription drug monitoring program use. The AMA continues its efforts to address the opioid epidemic by developing resources and advocating for policies intended to reduce opioid-related harm, increase access to effective treatment for pain, and broaden the base for accessing medication-assisted treatment for those suffering from opioid use disorder. A new opioid microsite was developed that contains a multitude of AMA and Federation-based resources addressing the intersection of pain, opioids, and addiction. Physicians are learning/following best practices for opioid prescribing. They continue, in increasing numbers, to access educational resources, register with and check patient information in prescription drug monitoring programs, obtain waivers for offering office-based treatment with buprenorphine, and co-prescribe naloxone for patients at risk of opioid overdose. Naloxone is now widely available for overdose interventions. Additionally, new partnerships were formed with hospitals, payers, government, and others in the public and private sector to work collaboratively to advance a public health solution to this enduring problem.

Health Solutions Group

In 2017 the AMA launched the Integrated Health Model Initiative (IHMI), a collaborative effort across health care and technology stakeholders that will unleash a new era of better, more effective patient care. IHMI supports a continuous learning environment to enable interoperable technology solutions and care models that will evolve with real-world use and feedback. IHMI uses the best
available science to incorporate essential data elements around function, state, and patient goals. Key components of IHMI are: digital communities around costly and burdensome clinical areas, a physician-led validation process to review clinical applicability, and a data model for organizing and exchanging information. Since the public release in mid-October 2017, 1,000 individuals from 47 states and 33 countries have joined the IHMI platform, in addition to 17 collaborating organizations resulting in wide representation across external stakeholders.

In 2017 AMA Business Solutions, a subsidiary of the American Medical Association, collaborated with LexisNexis® Risk Solutions to create VerifyHCP™, a pre-populated physician data solution that aims to address the issue of inaccurate provider directories by streamlining verification and updates across participating health plans. VerifyHCP allows physicians to focus their resources on patient care and gives patients access to the credible information they need to make important health care decisions. A single interface with highly accurate pre-populated physician profile data allows for updates to all participating payer directories at one time. The solution reduces the administrative burden on physicians and helps patients access more accurate directories when selecting physicians.

The AMA in 2017 also established the Digital Medicine Payment Advisory Group, a collective of clinical and technical subject matter experts with years of hands-on experience integrating digital medicine services and tools into clinical practice to provide leadership in digital medicine adoption. This initiative will help open access to high-quality and safe clinical care for patients and their physicians that promote improved health outcomes. The group has identified payment and coverage strategies—with an initial emphasis on coding, coverage, and payment for remote patient monitoring services—to help overcome existing barriers to adoption. This group of 14 experts has been working as a cohesive group for more than a year with clear goals and objectives set for 2018 and beyond.

**JAMA/JAMA Network**

*JAMA* and the JAMA Network continue to expand the amount of content produced, the formats for distribution, the audiences they engage, and the impact their content has on research and practice. In 2017, *JAMA* users viewed full-text content over 31 million times and downloaded and listened to over 2 million podcasts. Downloads across the JAMA Network are up significantly as well, with over 70 million full-text views in 2017. *JAMA's* impact factor rose to 44.4, and *JAMA Oncology* debuted with an impact factor of 16.6. Finally, in October, the JAMA Network announced the launch of JAMA Network Open, an open access journal that launched in 2018.

**Communications**

The AMA played a central role in health system reform by clearly and firmly articulating a positive vision for bipartisan reform, and by calling attention to the deficiencies in the various proposals that came through Congress. The AMA commanded attention as demonstrated by a nearly 50 percent share of voice of media coverage among its advocacy peers. The AMA was referenced more often—and by more media publications, broadcasts, and blogs—than any other health care organization in 2017, earning nearly 33 billion media impressions, which is more than on any other single issue in AMA history.

The AMA unveiled a bold brand campaign, the first in more than a decade, that in a brief timeframe helped change perceptions of the AMA among students, residents, and physicians and paved the way for the introduction of an ambitious membership campaign.
Physician Engagement

Physician Engagement: AMA launched the new “Membership Moves Medicine™” campaign, a multi-channel effort to educate prospective and existing members about AMA’s activities and accomplishments on behalf of patients and physicians—and provide tangible and compelling reasons to join the AMA. It also launched a digital communities pilot program (with nearly 4,000 initial participants across three main communities: IMGs, Medical Students, Physician—Reinventing Medical Practice) and the initial version of the Ambassador Program that leverages nearly 1,000 AMA council and section leaders to represent the AMA online, in social forums, and at live events.

Digital Transformation: The AMA launched more than 15 new areas on the AMA website, including a new House of Delegates/Annual Meeting site. The AMA revised the digital marketing platform with new landing pages, sign-up process, and account management center, greatly improving membership conversion rates. The website updates include five new thematically driven destinations that combine news storytelling and aggregated high-value content on subjects that connect with audiences for impact and engagement (i.e., compelling stories, research, tools, and resources to show the AMA’s impact and how members move medicine).

Membership: In 2017 the AMA saw its seventh consecutive year of membership growth, a 1.8 percent increase in dues paying members over 2016, and maintained a strong retention rate of nearly 82 percent.

Resident Program: The AMA launched the new GCEP Resident Education Platform (formerly known as the “Introduction to the Practice of Medicine”). By converging the strategic goals of Physician Engagement, the Education Center (EC), and ACE, the AMA was able to improve significantly on the former program’s appeal and performance. The new platform advances AMA content offerings and encourages frequent engagement; it provides opportunity to extend and expand programming at the UME, GME, and CME levels; and it drives lifelong affiliation and membership with the AMA.

EVP Compensation

During 2017, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,053,515 in salary and $987,735 in incentive compensation, reduced by $5,114 in pre-tax deductions. Other taxable amounts per the contract are as follows: $14,478 imputed costs for life insurance, $7,620 imputed costs for executive life insurance, $2,500 paid for health club fees, $2,880 paid for parking and $3,500 paid for a physical. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the “AMA 2017 Annual Report.”
REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-A-18

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2017 through February 2018

Presented by: Gerald E. Harmon, MD, Chair

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2017 through February 2018 and is written pursuant to AMA Policy D-490.983, “Annual Tobacco Report.”

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

According to the Centers for Disease Control and Prevention (CDC) tobacco use remains the leading preventable cause of disease and death in the United States with an estimated 480,000 premature deaths annually, including more than 41,000 deaths resulting from secondhand smoke exposure. These data translate to about one in five deaths related to tobacco use annually, or 1,300 deaths every day. From March 2017 through February 2018, the CDC released 13 MMWRs related to tobacco use. These reports provide useful data that researchers, health departments, community organizations and others use to assess and develop ongoing evidence-based programs, policies and interventions to eliminate and/or prevent the economic and social costs of tobacco use.

2017:

2018

Youth Smoking Rates and Trends

According to the June 16, 2017 MMWR, which was an analysis of data from the 2011-2016 National Youth Tobacco Surveys (NYTS), there were substantial increases in electronic cigarette (e-cigarette) and hookah use among high school and middle school students, whereas significant decreases were observed in the use of cigarettes, cigars, smokeless tobacco, pipe tobacco, and bidis. The NYTS is a cross-sectional, voluntary, school-based, pencil-and-paper questionnaire self-administered to U.S. middle and high school students. A three-stage cluster sampling procedure was used to generate a nationally representative sample of U.S. students attending public and private schools in grades 6–12.

Specifically among all high school students, current use of any tobacco product did not change significantly from 2011 (24.2%) to 2016 (20.2%); however, there was a significant decrease in current use of any combustible tobacco product (21.8% to 13.8%). The use of e-cigarettes increased from 1.5% to 11.3% during this same period.
In 2016, among youth tobacco products users, 47.2% of high school students and 42.4% of middle school students used 2 or more tobacco products. E-cigarettes were the most commonly used tobacco product among high school (11.3%) and middle school (4.3%) students.

The authors highlight the need for sustained efforts to implement proven tobacco control policies and strategies that are critical to preventing youth use of all tobacco products. There is concern about the rising popularity of e-cigarettes. The FDA deeming rule that went into effect in August 2016, gives FDA jurisdiction over products made or derived from tobacco, including e-cigarettes, cigars, pipe tobacco and hookah tobacco. This oversight could reduce youth tobacco product initiation and use if combined with other environmental strategies such as taxes and raising the purchase age to 21.

Adult Smoking Rates

To assess progress toward the Healthy People 2020 target of reducing the proportion of U.S. adults aged 18 years and older who smoke cigarettes to 12.0% or lower, the January 19, 2018 MMWR analyzed data from the 2016 National Health Interview Survey (NHIS). The NHIS is an annual, nationally representative in-person survey of the noninstitutionalized U.S. civilian population. The NHIS core questionnaire is administered to a randomly selected adult in the household (the sample adult).

In 2016, the prevalence of current cigarette smoking among adults was 15.5%, which was a significant decline from 2005 (20.9%); however, no significant change has occurred since 2015 (15.1%). Current cigarette smoking prevalence was higher among males (17.5%) than among females (13.5%). By age group, prevalence was higher among adults aged 25–44 years (17.6%) and lower in adults 65 and older (8.8%).

Veterans Smoke at Higher Rates

The January 12, 2018 MMWR looked at tobacco use among military veterans in the U.S. from 2010-2015. An estimated 30% of veterans reported tobacco use and among those, 7% reported use of two or more tobacco products. Cigarettes were the most commonly used tobacco product (21.6%), followed by cigars (6.2%), smokeless tobacco (5.2%), roll-your-own tobacco (3.0%), and pipes (1.5%). Within subgroups of veterans, current use of any of the assessed tobacco products was higher among persons aged 18–25 years (56.8%), Hispanics (34.0%), or persons with less than a high school diploma (37.9%).

The authors highlighted the significant impact of tobacco use among veterans on healthcare costs. During 2010, the Veterans Health Administration (VHA) spent an estimated $2.7 billion on smoking-related ambulatory care, prescription drugs, hospitalization, and home health care for the segment of the veteran population receiving VHA services. Tobacco use among active military personnel can eventually contribute to VHA expenditures. Reducing tobacco use among both active duty military and veterans can therefore result in a substantial reduction in tobacco-related morbidity and mortality and billions of dollars in savings from averted medical costs.

Recommendations to address the high rates of tobacco use in veterans include promoting cessation to current military personnel and veterans, implementing tobacco-free policies at military installations and Veterans Affairs medical centers and clinics, increasing the age requirement to buy tobacco on military bases to 21 years, and eliminating tobacco product discounts through military retailers.
AMA TOBACCO CONTROL ACTIVITIES

AMA Calls on Walgreens to Stop Selling Cigarettes

According to an online survey, 82% of Walgreens’ shoppers surveyed agreed that “the primary focus of stores with pharmacies should be to sell products that help people get and stay healthy” and 73% reported that they favor a ban on tobacco sales at Walgreens. The survey was conducted by the Truth Initiative, a national nonprofit focused on eliminating tobacco use through youth engagement research and education.

The survey results were highlighted in a joint letter (January 2018) signed by the AMA and other medical and health groups calling on Walgreens to discontinue sales of tobacco products. The letter to the Walgreens Chief Medical Officer cited research that confirms that retail marketing, in-store advertising, and displays are associated with compromising quit attempts and cause the initiation and progression of tobacco use among young people. The letter also called on Walgreens to:

- refrain from opposing policies that reduce tobacco use including those that require tobacco-free retailers and regulate retail licensing and density;
- eliminate sales of tobacco products while continuing to sell FDA approved nicotine therapies; and
- employ pharmacy-based plans to assist smokers with quit attempts including cessation counseling.

The AMA opposed sales of tobacco products in pharmacies as early as 2003. As stated in the Board of Trustees Report 02-I-03, “Opposition to Sales of Tobacco in Pharmacies”, the sale of tobacco products in pharmacies presents an ethical conflict for pharmacists; sends unhealthy, mixed messages to consumers about the role of pharmacies in the community; is not a clear economic necessity; and negatively affects the health of our patients. By selling and promoting tobacco, pharmacies undermine the tobacco control efforts of the rest of the health community.

AMA first adopted its policy calling for a ban on sales of tobacco products in pharmacies in 2009 and reaffirmed Policy D-495.994, in 2013.

Declines in Smoking in Movies Stalled since 2010

In response to the July 7, 2017, MMWR, Tobacco Use in Top-Grossing Movies - United States, 2010–2016, the AMA signed on to a letter to film industry leaders demanding that movie producers, distributors and exhibitors apply an R-rating to all films that include depictions of smoking or tobacco. According to the MMWR, the average number of tobacco incidents increased 55% in youth-rated movies with any tobacco depiction from 22 incidents in 2010 to 34 incidents in 2016. Previous studies had shown a steady decline, and if that trend had continued, all youth-rated films would have been smoke-free by 2015.

The AMA was one of several organizations, including the American Academy of Pediatrics, American College of Physicians, American Heart Association, American Lung Association, American Public Health Association and others, who signed the letter citing the report. The medical and public health groups set a deadline of June 1, 2018 for the industry to end its practice of using tobacco depictions in youth-rated movies because research has shown these images have a direct impact on children.
In a press statement, AMA President Dr. David O. Barbe said “We urge the motion picture industry to listen to the collective plea of the nation's physicians and once and for all apply an 'R' rating to films depicting cigarette smoking to help keep lethal, addictive tobacco products out of the hands of young people. We will continue to advocate for more stringent policies and support efforts to protect our nation's youth from the dangers caused by tobacco use.”

AMA House of Delegates Continues to Support Strong Tobacco Control Policies

The AMA House of Delegates adopted new or modified existing tobacco control policies at its 2017 Annual Meeting and 2017 Interim Meeting. Among the policies adopted was H-490.905, “Use of Tobacco Industry-Sponsored Cessation and Prevention Materials,” which called on physicians to use smoking cessation materials from credible sources when talking with their patients. Physicians and health organizations are urged to avoid providing to patients and consumers information or materials on tobacco cessation that come from tobacco companies or other groups aligned with the tobacco industry.

The AMA also adopted D-490.974, “Corrective Statements Ordered to be Published by Tobacco Companies for the Violation of the Racketeer Influenced and Corrupt Organizations Act,” that calls for educating the public and policymakers about the organized conspiracy of several tobacco companies to commit fraud and mislead consumers about the negative health effects of tobacco use. In 2006, several tobacco companies were found in violation of the U.S. Racketeer Influenced and Corrupt Organizations (RICO) Act. Ten years after that decision, the U.S. Court of Appeals finalized the content of the corrective statements the companies are required to make public.

Under this policy, the AMA will work with state and medical specialty societies as well as public health organizations to increase public awareness of the tobacco companies that were found in violation of the RICO Act and the corrective statements that they are being required to publish. The policy also encourages state and medical specialty societies to work with appropriate public health organizations in their states to help identify public policies that may have been directly or indirectly influenced by tobacco companies, and encourage lawmakers to reject any potential tobacco industry influences on future policy.

AMA Fights for Tobacco Provisions in Appropriations Bill

The AMA joined with medical groups and health organizations to oppose the House Agriculture, Rural Development, Food and Drug Administration (FDA), and Related Agencies appropriations bill. The bill called for weakening the FDA’s authority over certain tobacco products and would exempt the Agency’s oversight over large and premium cigars entirely. This bill was of particular concern because it would have created a loophole that would enable manufacturers of some cheap, fruit- and candy-flavored cigars to escape from FDA oversight and prevent FDA from implementing common sense rules for all cigars.

A 2009 law requires FDA review of new or changed tobacco products and applies to new products introduced after February 15, 2007. This review is critical to stop tobacco companies from introducing products that are more appealing to children, more addictive and even more harmful.

The House appropriations language would completely exempt from this requirement any e-cigarettes or cigars that are already on the market. Exempted products would include cigars and e-cigarettes in an array of candy and fruit flavors that clearly appeal to children. The proposed language would allow these products to stay on the market without any FDA review to determine whether they attract children or otherwise harm public health.
The advocacy efforts by the medical and health groups were successful. In March 2018, the House policy riders to exempt “large and premium cigars” from FDA oversight and to change the “grandfather date” in order to exempt e-cigarettes, cigars, and other tobacco products from an FDA product review requirement were not included in the final bill.
Subject: Ownership of Patient Data

Presented by: Gerald E. Harmon, MD, Chair

At the 2017 Annual Meeting the House of Delegates adopted Policy D-315.976, “Ownership of Patient Data,” which asks that our American Medical Association undertake a study on the misuse of patient information by hospitals, corporations, insurance companies, and 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.

The testimony on this resolution was unanimously in favor of adoption. Those who spoke discussed the many challenges related to accessing patient data and medical records by physicians, and agreed that a study is needed to better identify these obstacles and begin exploring solutions to the use and misuse of patient information.

This informational report provides an overview of the current laws and regulations at the state and federal levels that address ownership, access and use of patient data including under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations. It also looks at controls and processes in place to address physician and healthcare industry access and use of patient information.

LEGAL AND REGULATORY OVERVIEW

Ownership of, and access to, patient data contained in a medical record are distinct concepts under the law. State laws vary on the topic of who owns a patient’s medical record. As depicted in the following graphic from Health Information & the Law the majority of state legislatures either grant ownership of the medical record to the clinician or institution, or remain silent on medical
Ownership of patient data is not specified under HIPAA. Patients, however, have broad access rights to their protected health information (PHI). Patients can also exercise control over whether and how their health information is used and disclosed for certain purposes, including marketing. The following points are highlighted for patients by the U.S. Department of Health & Human Services Office of Civil Rights document titled “Your Health Information Privacy Rights”:

1. Generally, patient health information cannot be used for purposes not directly related to care without permission. For example, a doctor cannot give it to a patient’s employer, or share it for things like marketing and advertising, without written patient authorization and

2. patients can ask that their health information not be shared with certain people, groups, or companies.

The Office for Civil Rights (OCR) has an online complaint portal in which anyone can file a complaint against covered entities and their business associates if there is a potential violation of an individual’s health information privacy rights or other violation of the Privacy, Security, or Breach Notification Rules. A “Covered Entity” is defined as either a health plan, health care clearinghouse, or health care provider who transmits PHI in electronic form. “Business Associate” is defined in part as a person that provides data transmission services with respect to PHI to a covered entity and that requires access on a routine basis to such PHI. Additionally, a Business Associate may also be a subcontractor that creates, receives, maintains, or transmits PHI on behalf of the business associate. If OCR determines that a covered entity or business associate may have violated the HIPAA Rules, that entity or business associate must either voluntarily comply with the HIPAA Rules, take corrective action, or agree to a settlement with the injured party. Additionally, a civil monetary penalty (CMP) may be imposed on the covered entity if the corrective action is not viewed as satisfactory.

PHYSICIAN ACCESS TO PATIENT RECORDS

Much of the discussion on this resolution centered on the obstacles in accessing patient and medical record data by physicians. This can be a symptom of the physician’s contract with the hospital or healthcare entity they are employed by or contracted for services with, or the electronic healthcare record vendor that they or their employer has contracted with.

Contractual Considerations – Employment Agreements

In cases where a physician is an employee of a hospital or other healthcare entity, access to patient and medical record data both during and following employment is often addressed by the employment agreement. The AMA, as well as many state medical societies, provides physicians resources to assist in navigating various issues and ensuring a fair and comprehensive employment agreement. This is especially important during separation.

Depending on its terms, an employment or independent contractor (IC) arrangement between a physician and a hospital or health system should specify who owns the patient records and patient data, and which parties have access rights to the data, including after termination. The parties will negotiate their rights with respect to ownership of and access to the records for specified purposes, including upon patient request.

The “AMA Annotated Model Physician-Hospital Employment Agreement” addresses access to patient records and confidentiality in Section 8.7. While continuity of care is a high priority upon the termination of the contractual employment relationship between a hospital and a physician,
equally important is contractual language that acknowledges the physician’s entitlement to copies of patient charts and records. “The employer may wish to specify that, upon termination, the physician will not be entitled to keep or copy charts, files, or patient lists;” however, it is common practice to negotiate a provision that allows the physician to obtain the patient records after termination for situations such as a malpractice action, administrative investigation or proceeding against the physician, as they would be necessary to the physician’s defense.

**AMA Advocacy Efforts and Resources**

The AMA model state bill titled “Physician Employment Patient Notification and Records Act” states that, in order to ensure that the termination of their physicians’ employment does not disrupt their care; patients must be timely provided with information enabling them to obtain care from alternative physicians or continue to receive care from their physicians post-termination. The model bill also states that access to medical records should be addressed in the employment agreement and should state that the physician is entitled to copies of patient charts and records relating to the physician’s provision of physician services: (1) upon written request from the patient, or (2) when records are necessary to address any current or future legal, professional, administrative, regulatory, or other issues, claims, allegations, proceedings, or investigations against, involving or in connection with those services.

The AMA Advocacy Resource Center (ARC) has developed a legislative campaign with the goal of assisting physicians with issues throughout the employment spectrum including negotiating employment contracts, maintaining autonomy during employment, and terminating the relationship.

**Federal Regulation and Guidance**

The U.S. Department of Health and Human Services (HHS) has also weighed in on the related matter of charging for access to patient or medical records. In March of 2016, OCR issued new guidance including the stipulation that in the case of a request for an electronic copy of PHI maintained electronically, covered entities may charge a flat fee not to exceed $6.50 (inclusive of all labor, supplies, and postage).

**Accessing Data through an Electronic Health Record (EHR) Vendor**

The second party with which a physician can encounter issues regarding access to patient and medical record data is with their electronic health records vendor. Concerns over ensuring data are readily available to physicians and patients, prompted HHS and the Office of the National Coordinator (ONC) to release a Health IT Playbook to help clinicians navigate the EHR market. HHS and ONC also have developed an EHR contracting guide, “EHR Contracts Untangled: Selecting Wisely, Negotiating Terms, and Understanding the Fine Print.” The Health IT Playbook and contracting guide are meant to assist clinicians and healthcare institutions in negotiating contract terms with EHR vendors. The publication includes guidance and sample contract terms addressing compliance with HIPAA and the control and access to EHR data - including the avoidance of data blocking.

**Contractual Considerations – EHR Vendor Agreement**

The use of an EHR contract, including a Business Associate Agreement (BAA), can provide a covered entity, such as a physician, the legal protection necessary to use and disclose patient PHI with a health information exchange (HIE) or third party subcontractor for various purposes. These
activities may include health care activities, including but not limited to, claims processing, data analysis, or quality assurance.

Physicians are encouraged to ensure the contract with the EHR vendor clearly defines data rights. Failing to clearly address data access rights in the BAA and any other vendor contract can severely impact the physician’s ability to share data with patient registries and HIEs as well as easily transition to a new EHR vendor in the future.

The EHR vendor contract and BAA should also clearly identify what the EHR can and cannot do with the data that is created and used by the physician. The vendor agreement or BAA should address whether or not the vendor is permitted to aggregate de-identified data across different covered entities for medical research, population health management, or other purposes.

AMA Tools and Resources

The AMA’s Steps Forward™ module titled “Electronic Records Software Selection and Purchase” provides guidance on negotiating favorable contract terms. The AMA also has model legislation created in response to Policy D-478.972 that required the AMA to develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to HIEs. The bill, titled “An Act to Improve the Transparency of Electronic Health Record Systems Costs and Promote Data Sharing,” identifies appropriate disclosures including data sharing capabilities and detailed fees.

Federal Regulations and Guidance

There are cases where it may be challenging to implement this guidance in today’s environment. Because of unequal bargaining power and the fact that a hospital or health system, and not an individual physician, often contracts with an EHR vendor, it can be difficult for a physician, practice, or institution to obtain favorable contract provisions. The 21st Century Cures Act (the Act) directs the Secretary of HHS to develop a strategy to reduce EHR regulatory and administrative burdens while placing new requirements upon developers as a condition of certification and maintenance of certification. These requirements address many of the AMA’s long-standing concerns with EHRs, including prohibiting vendor data blocking; improving the usability, interoperability, and security of EHRs; and testing certified EHR technology in real-world settings.

The Act provides for penalties of up to $1.0 million per instance for any developers, networks, or exchanges that the Office of Inspector General (OIG) of HHS finds to have committed information blocking.

The AMA has actively provided feedback to ONC, OIG, and HHS on what should and should not be considered blocking and publically, through numerous comment letters, supports the operationalization of the Act’s information blocking requirements for health IT vendors. The AMA is expecting the release of the proposed rule around the implementation of the Act’s requirements in April of 2018.

USE OF PATIENT RECORDS BY THE HEALTHCARE INDUSTRY

A search on use of EHR records reveals instances where health systems and EHR vendors are entering data agreements to provide de-identified, anonymized data to organizations including medical device manufacturers, technology providers, health information aggregators and clinical researchers. Two recent examples include a partnership between Mercy Health System and Medtronic to share de-identified data from approximately 80,000 patients with heart failure to
focus on how patients respond to Cardiac Resynchronization Therapy (CRT). In another recent example Google partnered with academic medical centers to explore how machine learning can be used to mine EHR data for improved outcomes.

EHR vendors also use de-identified patient data gathered through use of their products in population health tools. In a less common scenario, some EHR vendors are providing de-identified, anonymized patient data to health information organizations (HIO) who in turn merge the data with other available datasets and license the combination to government agencies, academia, and businesses for a range of medical research and commercial purposes. This includes pharmaceutical manufacturers who use this information in various aspects of clinical development and commercialization. HIOs also use anonymized patient data to deliver evidenced-based insights about drug safety issues as well as the quality and cost of care.

The search on use of anonymized EHR records also revealed a number of white papers and opinions on the promise of using EHR data for clinical research and improving outcomes stating, however, that there are a number of challenges yet to be overcome to make this effective.

A LOOK FORWARD

A scan of the health technology market shows that data continues to grow in importance. Several companies have announced initiatives and platforms that provide patients access and control of their information. These organizations include a Virginia-based Health IT company, Health Wizz, who has created a patient-data platform that allows patients pull their data into the Health Wizz app via EHR patient portals and then use the DirectTrust framework to send their data to providers and other organizations. Apple is giving iPhone users a means to download their health records from a patient portal, store them safely, and share them with others. The Apple feature, Health Records, is currently in a beta release which includes integration with twelve participating hospital systems. Most recently, CMS Administrator Seema Verma announced the launch of the MyHealthEData Initiative. “MyHealthEData is a government-wide initiative that will break down the barriers that contribute to preventing patients from being able to access and control their medical records. MyHealthEData makes it clear that patients should have access and control to share their data with whomever they want, making the patient the center of our health care system. Patients need to be able to control their information and know that it’s secure and private. Having access to their medical information will help them make decisions about their care, and have a better understanding of their health.”

AMA POLICY

The AMA has several policies related to this topic (see Appendix). Policy H-315.973, “Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data,” which was last updated and reaffirmed in 2013, establishes principles around the use of these data that include compliance with HIPAA, requires physician consent for analysis of the data, and requires data to remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.

In addition, Policy H-315.975, “Police, Payer, and Government Access to Patient Health Information,” and Policy H-315.987, “Limiting Access to Medical Records,” look to further define who should and should not have access to this information. Finally, Ethical Opinions E-3.2.4, “Access to Medical Records by Data Collection Companies,” E-3.2.1 “Confidentiality,” and E-3.3.2, “Confidentiality and Electronic Medical Records,” are also relevant to this discussion.
CONCLUSION

This is an issue that will become more complicated as the healthcare industry looks to further connect disparate patient information in an effort to map the patient journey and improve health outcomes. Throughout the progression it is important that patients have appropriate access to their data and physicians have the tools and controls they need to be good stewards of their patients’ information while at the same time have the ability to share information to seamlessly coordinate the best care. In support of these initiatives, the AMA has actively engaged with HHS, OIG, and ONC and has broad policy in place covering all aspects of patient record maintenance, access and control.

Physicians and healthcare institutions have the ability to control use and access to the patient data they create within an EHR through agreements with the EHR vendor and business associate agreements. Additionally all PHI contained in the EHR is protected under HIPAA.

Our AMA has taken a leadership role in ensuring appropriate use and access of these data by (1) working with ONC and HHS to encourage operational implementation of provisions in the 21st Century Cures Act to prohibit EHR vendors from blocking access to data and limiting a physician’s ability to effectively utilize their EHR system; (2) providing physicians and practices with resources on negotiating employment and independent contractor agreements to assist in clarifying ownership of and access to patient information upon termination of employment or contracting; (3) supplying physicians and practices with educational tools about favorable EHR vendor contract terms covering ownership of, access to, and use of patient information; (4) educating physicians and practices on how to file a HIPAA complaint with the OCR; and (5) providing the Federation of Medicine with model legislation that ensures appropriate handling and access to patient data.

Lastly, technologies are emerging every day that are focused on putting patient data in the patient’s hands with the capability of providing access and control to the patient with a mechanism of doing so in a systematic way.
REFERENCES

4. “Individuals’ Right under HIPAA to Access their Health Information 45 CFR § 164.524” https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/#newlyreleasedfaqs

APPENDIX – AMA POLICIES RELATED TO THIS REPORT

AMA Code of Medical Ethics

Code of Medical Ethics Opinion E-3.2.4, “Access to Medical Records by Data Collection Companies”

Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality.

Information contained in patients’ medical records about physicians’ prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians’ treatment recommendations, such as pharmaceutical or medical device companies.

Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to
enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.

Physicians who propose to permit third-party access to specific patient information for commercial purposes should:
(a) Only provide data that has been de-identified.
(b) Fully inform each patient whose record would be involved (or the patient’s authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.

Physicians who propose to permit third parties to access the patient’s full medical record should:
(a) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient’s medical record.
(b) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.
(c) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.

Code of Medical Ethics Opinion E-3.3.1, “Management of Medical Records”
Physicians have an ethical obligation to manage medical records appropriately.

Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.

In keeping with the professional responsibility to safeguard the confidentiality of patients’ personal information, physicians have an ethical obligation to manage medical records appropriately.

This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient’s authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.

To manage medical records responsibly, physicians (or the individual responsible for the practice’s medical records) should:
(a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients’ medical records by unauthorized staff.

(b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:
1. Immunization records, which should be kept indefinitely
2. Records of significant health events or conditions and interventions that could be expected to have a bearing on the patient’s future health care needs, such as records of chemotherapy

(c) Make the medical record available:
1. As requested or authorized by the patient (or the patient’s authorized representative)
2. To the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death)
3. As otherwise required by law
(d) Never refuse to transfer the record on request by the patient or the patient’s authorized representative, for any reason.

(e) Charge a reasonable fee (if any) for the cost of transferring the record.

(f) Appropriately store records not transferred to the patient’s current physician.

(g) Notify the patient about how to access the stored record and for how long the record will be available.

(h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

**Code of Medical Ethics Opinion 3.3.2, “Confidentiality and Electronic Medical Records”**

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

(a) Choose a system that conforms to acceptable industry practices and standards with respect to:
   1. Restriction of data entry and access to authorized personnel
   2. Capacity to routinely monitor/audit access to records
   3. Measures to ensure data security and integrity
   4. Policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance

(b) Describe how the confidentiality and integrity of information is protected if the patient requests.

(c) Release patient information only in keeping with ethics guidance for confidentiality.

**Code of Medical Ethics Opinion 3.2.1, “Confidentiality”**

Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.

In keeping with the professional responsibility to safeguard the confidentiality of patients’ personal information, physicians have an ethical obligation to manage medical records appropriately.

This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient’s authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.

To manage medical records responsibly, physicians (or the individual responsible for the practice’s medical records) should:

(a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients’ medical records by unauthorized staff.
(b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:
1. Immunization records, which should be kept indefinitely
2. Records of significant health events or conditions and interventions that could be expected to have a bearing on the patient’s future health care needs, such as records of chemotherapy

(c) Make the medical record available:
1. As requested or authorized by the patient (or the patient’s authorized representative)
2. To the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death)
3. As otherwise required by law

(d) Never refuse to transfer the record on request by the patient or the patient’s authorized representative, for any reason.

(e) Charge a reasonable fee (if any) for the cost of transferring the record.

(f) Appropriately store records not transferred to the patient’s current physician.

(g) Notify the patient about how to access the stored record and for how long the record will be available.

(h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

AMA Policy

H-315.973, “Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data”
1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:

a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.
b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.
c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.
d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.
e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.
f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.
g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.
h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.
2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:

a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.
b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.
c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.
d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.

Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills.

H-315.975, “Police, Payer, and Government Access to Patient Health Information”
(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define “health care operations” narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or
mandatory disclosures made by physicians and other health care providers pursuant to ethical
guidelines or to comply with applicable state or federal reporting laws) without the express written
consent of the patient, or a court order or warrant permitting such access.

(5) Our AMA continues to strongly support and advocate a minimum necessary standard of
disclosure of individually identifiable health information requested by payers, so that the
information necessary to accomplish the intended purpose of the request be determined by
physicians and other health care providers, as permitted under the final privacy rule.

H-315.979, “Electronic Data Interchange Status Report”
Our AMA will: (1) work to establish consensus on industry security guidelines for electronic
storage and transmission of medical records as an important means of protecting patient privacy in
a manner that avoids undue and non-productive burdens on physician practices; and (2) develop
relevant educational tools or models in accordance with industry electronic security guidelines to
assist physicians in compliance with state and federal regulations.

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.

H-315.977, “Abuse of the Medical Record for Regulation or Financing the Practice of Medicine”
1) Our AMA continues to oppose the use of the physician office medical record as a tool of CMS,
as well as any other agency or third party, to regulate the financing and practice of medicine. (2)
The medical record shall be the property of the physician and the information contained therein, the
property of the patient. (3) The physician's office medical record should be used solely to document
the delivery of health care.

H-315.971, “Patient Information in the Electronic Medical Record”
AMA Guidelines for Patient Access to Physicians' Electronic Medical Record Systems:

(1) Online interactions are best conducted over a secure network, with provisions for privacy and
security, including encryption.

(2) Physicians should take reasonable steps to authenticate the identity of correspondent(s) in
electronic communication and to ensure that recipients of information are authorized to receive it.
Physicians are encouraged to follow the following guidelines for patient authentication: (a) Have a
written patient authentication protocol for all practice personnel and require all members of the
physician's staff to understand and adhere to the protocol. (b) Establish minimum standards for
patient authentication when a patient is new to a practice or not well known. (c) Keep a written
record, electronic or paper, of each patient authenticated.

(3) Prior to granting a patient access to his or her EMR, informed consent should be obtained
regarding the appropriate use of and limitations to access of personal health information contained
in the EMR. Physicians should develop and adhere to specific guidelines and protocols for online
communications and/or patient access to the EMR for all patients, and make these guidelines
known to the patient as part of the informed consent process. Such guidelines should specify
mechanisms for emergency access to the EMR and protection for and limitation of access to, highly sensitive medical information.

(4) If the patient is allowed to make annotations to his or her EMR (i.e., over-the-counter drug treatments, family medical history, other health information), the annotation should be indicated as authored by the patient with sourcing information (i.e., date and time stamp, login and IP address if applicable). A permanent record of all allowed annotations and communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

(5) Physicians retain the right to determine which information they do and/or do not import from a PHR into their EHR/EMR and to set parameters based on the clinical relevance of data contained within personal health records.

(6) Any data imported into a physician's EMR/EHR from a patient's personal health record (PHR) must preserve the source information of the original data and be further identified as to the PHR from which it was imported as additional source information to preserve an accurate audit trail.

(7) In order to maintain the legitimate recording of clinical events, patients should not be able to delete any health information in the record. Rather, in order to maintain the forensic nature of the record, patients should only be able to add notations when appropriate.

(8) Disclosures of Personal Health Information should comply with all applicable federal and state laws, privileges recognized in federal or state law, including common law, and the ethical requirements of physicians.

D-478.972, “EHR Interoperability”
Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.
INTRODUCTION

At the 2017 Annual Meeting, Policy D-215.987, “Studying Healthcare Institutions that Provide Child Care Services,” was adopted by the House of Delegates. This policy directs the American Medical Association (AMA) to work with relevant entities to study healthcare institutions to determine whether they provide childcare services and report on those findings at the 2018 Annual Meeting. This report, which is presented for the information of the House, provides background on child care services in health care and the implications of access to child care for physicians, as well as results of a study conducted by the AMA and other relevant research.

BACKGROUND

Physicians and residents often work irregular, long and overnight hours. Those with young children, specifically pre-school age and younger, face significant challenges in ensuring their children are cared for during work hours. This is especially true for dual-physician couples, physicians with spouses or partners that work full time, and single parent physicians. According to a 2017 AMA study of women physicians, 56 percent of respondents indicated onsite child care is either somewhat or strongly important in helping them balance work and family responsibilities. Some challenges physicians encounter in trying to secure care for their children include accessibility, affordability, and flexibility in hours. Many child care centers are full to capacity and have wait lists that keep parents waiting for months or even years before their child can be accepted.

Parents often experience stress and anxiety in dealing with family responsibilities that may affect their work. Contending with the task of obtaining care for young children can increase stress, which contributes to higher rates of burnout. Burnout can lead to diminished concentration, medical errors or misdiagnoses, lack of empathy, and lower professional satisfaction. Implementing tactics to reduce personal and professional stress is associated with decreased rates of burnout and having access to child care services, either onsite or near their workplace, can help alleviate stress and anxiety for parents. Research also demonstrates that employees report improved productivity while using quality child care. Despite the correlations between parental stress and burnout and between access to child care and improved productivity, access to onsite child care is limited for most employees.

AMA POLICY

AMA Policy H-215.985, “Child Care in Hospitals,” states that the AMA: (1) strongly encourages hospitals to establish and support child care facilities; (2) encourages that priority be given to children of those in training and that services be structured to take their needs into consideration; (3) supports informing the AHA, hospital medical staffs, and residency program directors of these
policies; and (4) supports studying the elements of quality child care and availability of child care on a 24-hour basis.

AMA Policy H-525.998, “Women in Organized Medicine,” states that the “AMA (3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings.”

DISCUSSION

Although there is evidence to show that reducing burnout and stress can lead to higher rates of job satisfaction and productivity, there is limited research showing a direct relationship between access to employer-sponsored child care services and employee productivity or job satisfaction, and what research is available is not consistent. An evaluation of existing research, published in Personnel Psychology, concluded there is not a credible evidence base to support the claims that employer-sponsored child care increases productivity and job satisfaction, or that it reduces absenteeism. However, another more recent review demonstrates that offering onsite child care improves employee recruitment and productivity, and reduces turnover and absenteeism. Notwithstanding evidence for or against its perceived or actual benefits, access to employer-sponsored child care is an important consideration for physicians when making major decisions about their practices and their families.

Only seven percent of employers in the U.S. report offering onsite child care as a benefit to their employees. Employers are most likely to provide Dependent Care Assistance Plans (56 percent) which help employees pay for child care with pre-tax dollars, or Child Care Resource and Referral (41 percent), which is simply access to information about child care in the area. These options are easier to implement and less costly than offering child care at or near the worksite. Employers that provide onsite child care are eligible for a federal tax credit and a state tax credit in many states. The tax credit is not applicable for funds provided to employees to assist with the cost of outside child care.

In the health care industry, access to employer-provided child care assistance is more prevalent than in other industries. According to the Bureau of Labor Statistics, 17 percent of civilian workers in the health care/social assistance sector have access to an employer-sponsored child care benefit. Thirty-seven percent of civilian workers in hospitals have access to a workplace program that provides for either the full or partial cost of child care in a nursery, day care center, or a baby sitter in facilities either on or off the employer's premises. According to the AMA women physician study, one in ten physicians indicated their employer offers onsite child care services, and of those, 19 percent have access to a subsidy, allowance, or discount to help cover the cost of the onsite care. The majority of respondents (57 percent) who report that their employer offers onsite care work in large practices with 26 or more physicians.

Residency and fellowship programs may also provide access to onsite or subsidized child care services. According to the AMA Residency & Fellowship Database® (FREIDA), which comprises information about more than 10,000 ACGME-accredited programs, 35 percent of the programs provide access to some type of child care service assistance, 3,344 offer onsite child care, 771 offer subsidies to assist with cost, and 528 offer both onsite care and subsidies. Users of the FREIDA database can find details about residency programs nationwide, including whether or not they offer
onsite child care or subsidies to assist with the cost of offsite child care. FREIDA is free for anyone to access and has enhanced features for AMA members.

The AMA sought collaboration from relevant stakeholders to conduct a census and capture specific data on employer-provided child care resources and assistance in the health care industry. However, since none of the organizations contacted expressed interest in pursuing the research topic, the AMA Professional Satisfaction and Practice Sustainability and Market Research groups developed and deployed the survey in-house.

The brief two-minute survey was distributed in an email invitation to 264 chief operating officers and human resource decision-makers in health care organizations. Only seven of the individuals invited to participate in the survey responded. The very small response rate could be due to a few factors: (1) the AMA does not have an established relationship with the professionals that make employee benefit decisions, so these individuals may not feel compelled to respond to an inquiry from the AMA, implying that the AMA may not be the most appropriate organization to effectively acquire this information; (2) employee benefit information may be confidential or leadership may be otherwise hesitant to share the information even on an anonymous basis; and (3) the initial target population was small due to the AMA’s lack of email contact information for the designated audience, resulting in a relatively low response rate. Given the extremely small response rate it is difficult and not advisable to draw any significant conclusions from this research. Additional research is needed to understand the prevalence of employer-provided or -assisted child care; however, it is not clear that the AMA is the appropriate organization to pursue such research, given our limited access to the relevant health care human resource decision-makers and leaders who are knowledgeable about the subject.

CONCLUSION

Access to child care can help physicians and physicians in training alleviate stress and focus on their patients while at work. Reducing stress can help physicians’ combat burnout and increase satisfaction in practice. Given the information available, it is apparent only a small portion of employers, including health care organizations, offers onsite child care services. However, determining how many health care organizations offer these benefits is difficult. Some employers provide subsidies to help employees pay for child care, and others provide access to resources to help employees locate and arrange child care.

Physicians seeking employment or medical students applying for residency or fellowship may be interested in obtaining information about child care options provided by potential employers or programs. Physicians seeking employment should always ask prospective employers about child care during exploration of compensation and benefits packages. Additionally, the AMA’s FREIDA database provides this information for many of the residency and fellowship programs listed. A comprehensive list of health care organizations and employers that provides employment benefit information such as availability of employer-sponsored child care could not be identified. Creating and maintaining such a list would be challenging due to limited availability of the information, limited access to the individuals that could disclose the information, the scale of the effort that would be required to collect and maintain it, and the frequency at which the information could change over time.
REFERENCES

Subject: Management of Physician and Medical Student Stress

Presented by: Gerald E. Harmon, MD, Chair

INTRODUCTION

At the 2017 Annual Meeting, Policy D-405.982, “Management of Physician and Medical Student Stress,” was adopted by the House of Delegates. This policy directs the American Medical Association (AMA) to produce a report on administrative and regulatory burdens placed on physicians, residents and fellows, and medical students, and pursue strategies to reduce these burdens. This report, which is presented for the information of the House, outlines various administrative and regulatory processes that adversely affect medical students, residents, and physicians. It also discusses AMA’s efforts, including existing policies, to reduce administrative burdens and address physician stress and burnout, one of the major effects of overwhelming and burdensome mandates, tasks and processes.

BACKGROUND

Physicians, residents and medical students face work-related stresses at high rates. Rates of stress and resulting burnout have increased in recent years, with more than 54 percent of physicians reporting at least one symptom of burnout in 2015 compared to 45 percent in 2011. Forty nine percent of physicians often or always experience symptoms of burnout. There are many influences, both internal and external, that contribute to stress and burnout among health professionals. Many of the external factors are imposed by administrative and regulatory factors outside of the physicians’ control.

AMA POLICY

The AMA maintains numerous policies supporting physician wellness and the importance of reducing and preventing physician stress and burnout, as well as the reduction in administrative/regulatory burdens associated with medical practice that can cause stress and lead to burnout.

The AMA recognizes burnout and stress, and their effects, as serious issues that affect physicians and medical students (Policy D-310.968, “Physician and Medical Student Burnout”). AMA places great importance on physician health and wellness and the need for continued education on its importance (Policy H-405.961, “Physician Health Programs”). AMA policy and the Code of Ethics recognize that when physician health and wellness is compromised the safety and care of the patient can be as well (Code of Ethics 9.3.1). The AMA supports programs to assist physicians in early identification and management of stress, and is committed to helping physicians, practices, and health systems identify and manage stress-related burnout (Policy H-405.957, “Programs on Managing Physician Stress and Burnout”). The AMA developed principles to guide residency programs in the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress (Policy H-310.979, “Resident Physician Working Hours and Supervision”). The
AMA encourages research on the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems (Policy H-95.955, “Physician Impairment”).


In addition, the AMA recognizes the unique stress medical students face with student debt and career choices, and has prioritized reducing medical student debt for legislative and other action (Policy H 305.928, “Proposed Revisions to AMA Policy on Medical Student Debt”). The prospect of finishing medical school without matching to a residency program is an added stress for medical students. Due to an increase in medical students and funding caps for graduate medical education (GME) programs, this has become increasingly burdensome. The AMA has also worked with CMS and other key organizations to increase the number of GME positions in order to accommodate the increase in medical students and accommodate the projected need for more physicians (Policy D-305.958, “Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy”).

DISCUSSION

Physicians report better professional satisfaction when they perceive that they are providing high-quality care, and obstacles to providing such care are major sources of professional dissatisfaction. Potential effects of physician stress and burnout include reduced empathy toward patients, poorer interactions during a visit, and medical errors, all which have the potential to decrease the quality of care. Burnout can lead to lower professional satisfaction and a desire to
reduce clinical hours or leave the practice of medicine.\textsuperscript{5, 6} There is evidence that stress and burnout affect medical students, residents and physicians at higher rates than the general U.S. population\textsuperscript{12, 13} and burnout has been connected to higher rates of suicidal ideation among physicians.\textsuperscript{14-17} In accord with the amplified attention on the effects of burnout, identifying the causes of stress and burnout has increasingly become the focus of research. Sources of stress and burnout among medical students and residents often include personal stressors, adjustment to a new work environment, ethical conflicts, financial issues, long hours, and exposure to human suffering.\textsuperscript{12, 18} While the practicing physician can be adversely impacted with the same stressors as medical students and residents, there are additional factors that are often tied to administrative and regulatory burdens experienced in practice. These factors affect physicians in multiple aspects of their work, including those related to the business of medicine, such as dealing with insurance companies and complying with regulatory requirements, as well as those related to the practice of medicine, such as licensing, credentialing, privileging, and maintenance of certification.

For physicians in practice, increased clerical burdens, including bureaucratic tasks and productivity requirements, are often cited as the top reasons physicians experience burnout.\textsuperscript{5, 19-21} The amount of time physicians spend doing administrative work includes more than half their day spent completing tasks in the electronic health record (EHR) system and almost 90 minutes of EHR work at home after hours.\textsuperscript{22} External factors detract from the quality of care physicians feel they can provide: nearly 40 percent of physicians report patient care is adversely impacted to a great degree by external factors such as third party authorizations, treatment protocols, and EHR design.\textsuperscript{5} Physicians also report that their EHRs have reduced or detracted from the quality of care, efficiency of practice, and interaction with patients.\textsuperscript{5}

Prior authorizations required by payers are another source of dissatisfaction and burden for physicians.\textsuperscript{23} In a 2016 AMA study, 75 percent of physicians reported that burdens associated with prior authorization are high or extremely high in their practice, and 90 percent indicated that prior authorizations can delay patients’ access to necessary care. On average, physicians or their staff complete 37 prior authorizations per week, with almost a quarter of physicians completing more than 40 per week.\textsuperscript{24} Obtaining prior authorizations involves inefficient and sometimes difficult processes that cost practices time and money, and often create stress and add pressure on physicians.

Increasing documentation requirements from Medicare and commercial payers have also added to physicians’ administrative workload. Dated documentation requirements for Evaluation and Management (E/M) services are considered to be over burdensome and no longer aligned with the modern practice of medicine.\textsuperscript{25} A 2013 survey indicated 92 percent of medical residents and fellows reported that documentation requirements were excessive.\textsuperscript{26} Clinical documentation requirements have increased over time with the mandated use of EHRs, increased quality reporting and other factors,\textsuperscript{27} contributing significantly to the administrative overload.

Regulatory requirements can be an additional source of time-consuming tasks that lead to stress and burnout for physicians. The QPP, a new Medicare physician payment system created by MACRA, comprises two tracks through which physicians and practices can participate: the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs). Participation in either track of the QPP requires specific uses of EHRs as well as recording, tracking and submitting quality and clinical practice improvement data to CMS in order to receive payment incentives and/or avoid payment penalties. While the changes implemented through the QPP represent an improvement over legacy Medicare pay-for-reporting programs, time and education are needed for physicians to feel prepared and comfortable conforming to new
requirements. A recent KPMG-AMA survey demonstrated that more than half of physicians are just somewhat knowledgeable about MACRA or QPP, and 41 percent have heard of MACRA or QPP but do not consider themselves knowledgeable. Additionally, 90 percent of the physicians participating in MIPS felt that the requirements are slightly or very burdensome, and the time required to report the required metrics is the most significant challenge. In addition to the strains created by tasks involved in day to day business of medicine, there are other processes that require time away from patient care and/or add stressful tasks to the physician workload. MOC, which is in some states a prerequisite for credentialing or insurance network participation, involves costly fees and lengthy tests which more than 80 percent of physicians feel are over burdensome. After years of advocating for change, physician groups, including the AMA, have prompted the American Board of Internal Medicine to relax its MOC requirements with the introduction of simplified open-book exams starting in 2018. There is also evidence that requests for information about mental illness and medical conditions on state medical license applications may deter physicians from seeking needed health care, for fear of the impact on licensure or employment. Leaving mental health issues or conditions untreated can result in further exacerbation of stress or depression that can lead to burnout, and can even lead to other illnesses and effects on job stability.

The AMA has dedicated numerous resources to reduce administrative burdens that cause stress and excessive workloads, assist physicians in navigating complex processes that come with new regulations, and combat the burnout epidemic. Through ongoing advocacy, the AMA works to address administrative burdens such as utilization management programs, prior authorization requirements, complex claim processes and other nonclinical activities that contribute to increased complexity and expense for physicians in practice. In addition, the AMA provides practical interpretation of legislation and regulations to help the practicing physician understand changes that may impact their practice. These are done via the AMA website, webinars, podcasts, STEPS Forward™ modules and live presentations to organized medicine. The AMA sections’ governing councils also continue their respective efforts to provide strategies and recommendations to address payment reform, prior authorization, and other issues that affect the practice of medicine.

In addition to advocacy, the AMA is working to provide useful tools for physicians to learn about and navigate new payment models, including MIPS and APMs. The “Navigating the Payment Process” topic page within the AMA website is a continuously growing wealth of information, resources and actionable tools to assist physicians in these complex administrative functions.

For physicians, residents, medical students and practices, AMA offers free access to its STEPS Forward online educational platform. The modules in the STEPS Forward platform provide simple, meaningful step-based strategies for addressing stress and burnout. Relevant modules include “Preventing Physician Distress and Suicide,” “Physician Wellness: Preventing Resident and Fellow Burnout,” “Improving Physician Resiliency,” “Preventing Physician Burnout,” and “Creating the Organizational Foundation for Joy in Medicine™.” Through the STEPS Forward site the AMA also provides access to the Mini-Z Burnout Survey, which enables organizational leaders, including residency program administrators, to periodically measure burnout levels among their staff and residents. The Mini-Z survey also affords the AMA an opportunity to create a robust data set to aid in the understanding of unique drivers of burnout and inform the AMA’s continued work in this area.
The Professional Satisfaction and Practice Sustainability strategy group, one of the AMA’s three strategic focus areas, continues to study and publish findings on burnout, its causes and effects, and strategies for addressing it.22, 23, 33-39 Currently in progress is a collaboration with Stanford Medicine WellMD Center and the Mayo Clinic to produce a follow-up study to the 2011 and 2014 burnout and satisfaction research. The AMA has collaborated with the Canadian and British Medical Associations for decades to co-host the International Conference on Physician Health, and will continue this long-standing partnership in 2018. The AMA will also co-host with Stanford University School of Medicine and the Mayo Clinic the second American Conference on Physician Health in 2019. Both of these highly attended conferences offer programming to educate and engage physicians, residents and medical students in organizational and individual level solutions to promote and improve physician and trainee health and wellness.

The AMA’s Accelerating Change in Medical Education strategy group is dedicated to fostering innovations in medical education that will create a learning environment and culture that ensures the psychological, emotional and physical wellbeing of medical students and residents. One example of the programming being put forth by this initiative is an online webinar that discusses national and local efforts to prevent burnout and promote wellness throughout the physician education continuum. The AMA also hosts a “Succeeding in Medical School” topic hub in which a variety of relevant resources cover issues such as easing stressors, managing medical school stress, and alleviating anxiety over exams.

CONCLUSION

The AMA recognizes the significant stressors and burdens that face medical students, residents and physicians throughout their careers, and the effects those tolls have on physician well-being and patient care. It is part of AMA’s strategic focus to help physicians create thriving, sustainable practices and improve professional satisfaction with the practice of medicine. The AMA is demonstrably committed to this work and continues to study the prevalence and severity of burnout among physicians and trainees, identify factors that contribute to burnout, and develop solutions to address the issue. The AMA will also persist in its efforts to advocate for better legislation and regulations that do not overburden physicians with excessive administrative tasks and requirements.
REFERENCES


25. Centers for Medicare & Medicaid Services, *2018 Physician Fee Schedule Proposed Rule,* CMMS, Editor. 2017. p. 373-8; Available from: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/)


Subject: Demographic Report of the House of Delegates and AMA Membership

Presented by: Gerald E. Harmon, MD, Chair

INTRODUCTION

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

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

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

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

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

DATA SOURCES

Lists of delegates and alternate delegates are maintained in the Office of House of Delegates Affairs and are based on official rosters provided by the relevant society. The lists used in this report reflect 2017 year-end delegation rosters.

Data on individual demographic characteristics are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all United States and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA membership and the total physician and medical student population are taken from the Masterfile and are based on 2017 year-end information.

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates is less than the 556 allotted
at the 2017 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. As such, the total number of delegates and alternate delegates is 985 rather than the 1,112 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 18% of AMA members and approximately 20.6% of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

Table 1 presents basic demographic characteristics of AMA membership and delegates along with corresponding figures for the entire physician and medical student population. Data on physicians’ and students’ current activities appear in Table 2. This includes life stage as well as present employment and self-designated specialty.

| Table 1. Basic Demographic Characteristics of AMA Members & Delegates, December 2017 |
|---------------------------------|--------------------------------|--------------------------------|
|                                 | 2017                          | 2017                          |
|                                 | AMA Members                    | All Physicians and Medical Students | AMA Delegates & Alternate Delegates |
| Total                           | 243,449                       | 1,306,770                     | 985                                |
| Mean age (years)                | 46.9                          | 51.9                          | 55.2                               |
| Age distribution (percent)      |                               |                               |                                    |
| Under age 40                    | 51.00%                        | 29.37%                        | 18.07%                             |
| 40-49 years                     | 9.93%                         | 18.88%                        | 12.59%                             |
| 50-59 years                     | 10.47%                        | 17.80%                        | 22.03%                             |
| 60-69 years                     | 10.88%                        | 16.98%                        | 31.78%                             |
| 70 or more                      | 17.72%                        | 16.98%                        | 15.53%                             |
| Gender (percent)                |                               |                               |                                    |
| Male                            | 64.94%                        | 65.55%                        | 71.57%                             |
| Female                          | 35.03%                        | 34.36%                        | 28.43%                             |
| Unknown                         | 0.03%                         | 0.09%                         | 0.00%                              |
| Race/ethnicity (percent)        |                               |                               |                                    |
| White non-Hispanic              | 54.26%                        | 51.74%                        | 69.24%                             |
| Black non-Hispanic              | 4.61%                         | 4.20%                         | 3.96%                              |
| Hispanic                        | 5.41%                         | 5.44%                         | 3.35%                              |
| Asian/Asian American            | 14.74%                        | 15.24%                        | 10.66%                             |
| Native American                 | 0.35%                         | 0.26%                         | 0.10%                              |
| Other                           | 2.64%                         | 2.52%                         | 1.42%                              |
| Unknown                         | 17.99%                        | 20.62%                        | 11.27%                             |
| Education (percent)             |                               |                               |                                    |
| US or Canada                    | 83.06%                        | 76.98%                        | 91.88%                             |
| IMG                             | 16.94%                        | 23.02%                        | 8.12%                              |

1 There were 127 vacancies as of year’s end, most of which are unfilled alternate delegate slots.
2 Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
3 Age as of December 31. Mean age is the arithmetic average.
4 Includes other self-reported racial and ethnic groups.
<table>
<thead>
<tr>
<th>Life Stage (percent)</th>
<th>2017</th>
<th>AMA Members</th>
<th>All Physicians and Medical Students</th>
<th>AMA Delegates &amp; Alternate Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td>23.46%</td>
<td>7.68%</td>
<td>7.21%</td>
</tr>
<tr>
<td>Resident&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td>23.61%</td>
<td>10.31%</td>
<td>5.38%</td>
</tr>
<tr>
<td>Young (under 40 or first 8 years in practice)</td>
<td></td>
<td>7.44%</td>
<td>15.86%</td>
<td>7.51%</td>
</tr>
<tr>
<td>Established (40-64)</td>
<td></td>
<td>22.90%</td>
<td>41.45%</td>
<td>50.36%</td>
</tr>
<tr>
<td>Senior (65+)</td>
<td></td>
<td>22.59%</td>
<td>24.71%</td>
<td>29.54%</td>
</tr>
<tr>
<td>Present Employment (percent)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-employed solo practice</td>
<td></td>
<td>8.22%</td>
<td>8.96%</td>
<td>13.60%</td>
</tr>
<tr>
<td>Two physician practice</td>
<td></td>
<td>1.57%</td>
<td>1.72%</td>
<td>1.93%</td>
</tr>
<tr>
<td>Group practice</td>
<td></td>
<td>22.53%</td>
<td>41.14%</td>
<td>39.49%</td>
</tr>
<tr>
<td>HMO</td>
<td></td>
<td>0.09%</td>
<td>0.17%</td>
<td>0.71%</td>
</tr>
<tr>
<td>Medical school</td>
<td></td>
<td>1.22%</td>
<td>1.68%</td>
<td>4.47%</td>
</tr>
<tr>
<td>Non-government hospital</td>
<td></td>
<td>2.33%</td>
<td>2.84%</td>
<td>5.79%</td>
</tr>
<tr>
<td>State or local government hospital</td>
<td></td>
<td>4.59%</td>
<td>6.96%</td>
<td>10.46%</td>
</tr>
<tr>
<td>US government</td>
<td></td>
<td>1.09%</td>
<td>2.03%</td>
<td>4.06%</td>
</tr>
<tr>
<td>Locum Tenens</td>
<td></td>
<td>0.19%</td>
<td>0.21%</td>
<td>0.10%</td>
</tr>
<tr>
<td>Retired/Inactive</td>
<td></td>
<td>10.21%</td>
<td>11.44%</td>
<td>5.79%</td>
</tr>
<tr>
<td>Resident/Intern/Fellow</td>
<td></td>
<td>23.61%</td>
<td>10.31%</td>
<td>5.38%</td>
</tr>
<tr>
<td>Student</td>
<td></td>
<td>23.46%</td>
<td>7.68%</td>
<td>7.21%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td></td>
<td>0.89%</td>
<td>4.87%</td>
<td>1.02%</td>
</tr>
<tr>
<td>Specialty (percent)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine</td>
<td></td>
<td>8.61%</td>
<td>11.74%</td>
<td>10.76%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td></td>
<td>19.17%</td>
<td>23.08%</td>
<td>20.20%</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td>13.93%</td>
<td>13.49%</td>
<td>21.52%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td></td>
<td>4.93%</td>
<td>8.77%</td>
<td>3.65%</td>
</tr>
<tr>
<td>OB/GYN</td>
<td></td>
<td>5.22%</td>
<td>4.73%</td>
<td>5.48%</td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td>3.57%</td>
<td>4.53%</td>
<td>5.08%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
<td>3.92%</td>
<td>5.28%</td>
<td>5.18%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td></td>
<td>3.69%</td>
<td>4.66%</td>
<td>3.86%</td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
<td>1.77%</td>
<td>2.24%</td>
<td>2.13%</td>
</tr>
<tr>
<td>Other specialty</td>
<td></td>
<td>11.75%</td>
<td>13.82%</td>
<td>14.92%</td>
</tr>
<tr>
<td>Students</td>
<td></td>
<td>23.46%</td>
<td>7.68%</td>
<td>7.21%</td>
</tr>
</tbody>
</table>

<sup>5</sup> See Appendix for a listing of specialty classifications.
<sup>6</sup> Students and residents are categorized without regard to age.
## Appendix

Specialty classification using physician’s self-designated specialties.

<table>
<thead>
<tr>
<th>Major Specialty Classification</th>
<th>AMA Physician Masterfile Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>General Practice, Family Practice</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Pediatrics, Pediatric Allergy, Pediatric Cardiology</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>Obstetrics and Gynecology</td>
</tr>
<tr>
<td>Radiology</td>
<td>Diagnostic Radiology, Radiology, Radiation Oncology</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Psychiatry, Child Psychiatry</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>Anesthesiology</td>
</tr>
<tr>
<td>Pathology</td>
<td>Forensic Pathology, Pathology</td>
</tr>
<tr>
<td>Other Specialty</td>
<td>Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified</td>
</tr>
</tbody>
</table>
INTRODUCTION

At the 2017 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-I-17, “Ethical Physician Conduct in the Media.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-8.12 – Ethical Physician Conduct in the Media

Physicians who participate in the media can offer effective and accessible medical perspectives leading to a healthier and better informed society. However, ethical challenges present themselves when the worlds of medicine, journalism, and entertainment intersect. In the context of the media marketplace, understanding the role as a physician being distinct from a journalist, commentator, or media personality is imperative.

Physicians involved in the media environment should be aware of their ethical obligations to patients, the public, and the medical profession; and that their conduct can affect their medical colleagues, other health care professionals, as well as institutions with which they are affiliated. They should also recognize that members of the audience might not understand the unidirectional nature of the relationship and might think of themselves as patients. Physicians should:

(a) Always remember that they are physicians first and foremost, and must uphold the values, norms, and integrity of the medical profession.

(b) Encourage audience members to seek out qualified physicians to address the unique questions and concerns they have about their respective care when providing general medical advice.

(c) Be aware of how their medical training, qualifications, experience, and advice are being used by media forums and how this information is being communicated to the viewing public.

---

*Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.*

© 2018 American Medical Association. All rights reserved.
(d) Understand that as physicians, they will be taken as authorities when they engage with the media and therefore should ensure that the medical information they provide is:

(i) accurate;

(ii) inclusive of known risks and benefits;

(iii) commensurate with their medical expertise;

(iv) based on valid scientific evidence and insight gained from professional experience.

(e) Confine their medical advice to their area(s) of expertise, and should clearly distinguish the limits of their medical knowledge where appropriate.

(f) Refrain from making clinical diagnoses about individuals (e.g., public officials, celebrities, persons in the news) they have not had the opportunity to personally examine.

(g) Protect patient privacy and confidentiality by refraining from the discussion of identifiable information, unless given specific permission by the patient to do so.

(h) Fully disclose any conflicts of interest and avoid situations that may lead to potential conflicts. (II, V, VII)
At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA’s activities during the most recent reporting period is presented.
APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2017 – MARCH 31, 2018

<table>
<thead>
<tr>
<th>Physicians Reviewed</th>
<th>SUMMARY OF CEJA ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Determinations of no probable cause</td>
</tr>
<tr>
<td>37</td>
<td>Determinations following a plenary hearing</td>
</tr>
<tr>
<td>11</td>
<td>Determinations after a finding of probable cause, based only on the written record, after the physician waived their plenary hearing right</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physicians Reviewed</th>
<th>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>No sanction or other type of action</td>
</tr>
<tr>
<td>8</td>
<td>Monitoring</td>
</tr>
<tr>
<td>12</td>
<td>Probation</td>
</tr>
<tr>
<td>6</td>
<td>Revocation</td>
</tr>
<tr>
<td>12</td>
<td>Suspension</td>
</tr>
<tr>
<td>2</td>
<td>Application denied</td>
</tr>
<tr>
<td>11</td>
<td>Censure</td>
</tr>
<tr>
<td>1</td>
<td>Reprimand</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physicians Reviewed</th>
<th>PROBATION/MONITORING STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Members placed on Probation/Monitoring during reporting interval</td>
</tr>
<tr>
<td>8</td>
<td>Members placed on Probation without reporting to Data Bank</td>
</tr>
<tr>
<td>4</td>
<td>Probation/Monitoring concluded satisfactorily during reporting interval</td>
</tr>
<tr>
<td>1</td>
<td>Memberships revoked due to non-compliance with the terms of probation</td>
</tr>
<tr>
<td>46</td>
<td>Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues</td>
</tr>
<tr>
<td>26</td>
<td>Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues</td>
</tr>
</tbody>
</table>
Last year, the Council on Long Range Planning and Development (CLRPD) created the educational module, Health Care Trends: Scientific Innovation, which accelerated its interest in artificial and augmented intelligence (AI), and prompted a series of discussions on these topics and their influences on the practice of medicine. Due to the complexity of the field, the Council developed this primer, which provides a history, definitions and components, and the status of AI in health care. Additionally, CLRPD postulated ways the field may progress, including the identification of opportunities and challenges for physicians. The Council feels it essential to provide a high-level look at this emerging issue that could dramatically affect medicine.

HISTORY OF AI

The most influential ideas underpinning computer science came from Alan Turing in 1950, who proposed a formal model of computing. Turing’s classic essay, Computing Machinery and Intelligence, imagines the possibility of computers created for simulating intelligence and explores many of the components now associated with artificial intelligence, including how intelligence might be tested, and how machines might automatically learn. Though these ideas inspired AI, Turing did not have access to the computing resources needed to translate his ideas into action.

In 1956, the field of AI came to the forefront with the Dartmouth Summer Research Project on Artificial Intelligence. The goal was to investigate ways in which machines could be made to simulate aspects of intelligence—the essential idea that has continued to drive the field forward. Subsequently, experts in the field of computer science research pioneered the foray into heuristic search—a method that produces a solution in a reasonable timeframe that is sufficient for solving a given problem. In the area of computer vision, early work in character recognition laid the basis for more complex applications such as face recognition. By the late sixties, work had also begun on natural language processing (NLP).

In the nineties, technological progress made the task of building systems driven by real-world data more feasible. Cheaper and more reliable hardware for sensing and actuation made robots easier to build. Further, the Internet’s capacity for gathering large amounts of data, and the availability of computing power and storage to process those data enabled statistical techniques that, by design, derive solutions from data. These developments have allowed AI to emerge in the past two decades as a profound influence on our daily lives.

DEFINITIONS AND COMPONENTS OF AI

The concepts of AI and machine learning have quickly become attractive to health care organizations; however, the related terminologies are not well understood. While many in the health care industry foresee their technological goals hovering just over the horizon, plotting a course to get there can be a difficult proposition, especially when the landscape is clouded by
marketing hyperbole, confusing vocabulary, technical terminology, and as-yet-undeliverable promises of truly automated insights.

Algorithms are a sequence of instructions used to solve a problem. Developed by programmers to instruct computers in new tasks, algorithms are the building blocks of the advanced digital world. Computer algorithms organize enormous amounts of data into information and services, based on certain instructions and rules.

Artificial Intelligence is the ability of a computer to complete tasks in a manner typically associated with a rational human being—a quality that enables an entity to function appropriately and with foresight in its environment. True AI is widely regarded as a program or algorithm that can beat the Turing Test, which states that an artificial intelligence must be able to exhibit intelligent behavior that is indistinguishable from that of a human.

Augmented Intelligence is an alternative conceptualization that focuses on AI's assistive role, emphasizing the fact that its design enhances human intelligence rather than replaces it.

Machine Learning is a part of the discipline of artificial intelligence and refers to constructing algorithms that can make accurate predictions about future outcomes. Machine learning can be supervised or unsupervised. In supervised learning, algorithms are presented with “training data” that contain examples with their desired conclusions, such as pathology slides that contain cancerous cells as well as slides that do not. Unsupervised learning does not typically leverage labeled training data. Instead, algorithms are tasked with identifying patterns in data sets on their own by defining signals and potential abnormalities based on the frequency or clustering of certain data.

Deep Learning is a subset of machine learning that employs artificial neural networks (ANNs) and algorithms structured to mimic biological brains with neurons and synapses. ANNs are often constructed in layers, each of which performs a slightly different function that contributes to the result. Deep learning is the study of how these layers interact and the practice of applying these principles to data.

Cognitive Computing, a term coined by IBM, is often used interchangeably with machine learning and artificial intelligence. However, cognitive computing systems do not necessarily aspire to imitate intelligent human behavior, but instead to supplement human decision-making power by identifying potentially useful insights with a high degree of certainty. Clinical decision support and augmented intelligence come to mind when considering this definition.

Natural Language Processing (NLP) forms the foundation for many cognitive computing exercises. The ingestion of source materials, such as medical literature, clinical notes, or audio dictation records requires a computer to understand what is written, spoken or otherwise being communicated. One commonly used application of NLP is optical character recognition (OCR) technology that can turn static text, such as a PDF of a lab report or a scan of a handwritten clinical note, into machine readable data. Once the data are in a workable format, the algorithm parses the meaning of each element to complete a task such as translating into a different language, querying a database, summarizing information or supplying a response to a conversation partner. In the health care field, where acronyms and abbreviations are common, accurately parsing through this “incomplete” data can be challenging.

On a basic level, classical computer programming takes rules and data as inputs, and generates an output or answer. Conversely, machine learning algorithms take data and answers as inputs, and
generate rules or insights as an output. For example, a computer may be given two sets of MRI images: one set that clearly shows a variety of brain tumors, and one that does not. By breaking down these images into machine-readable patterns, the computer can understand which patterns are likely to indicate a brain tumor and which represent healthy patients. When fed a new batch of images that may or may not contain tumors, the computer should be able to use that initial reference data to identify patterns that are similar to known positive diagnoses. Every time it makes an incorrect diagnosis, validated by a human clinician, it “learns” to adjust its criteria a little bit more by using the previous experience to inform its future decision-making. With enough training, it can become accurate enough to present reliable results to the user.

Humans complete these types of tasks almost without thought every moment of every day, but few algorithms are sophisticated enough to effectively mimic our natural capacity to process external input, extrapolate unspoken information from a query, consider complex ethical issues, use logic and reason to make a decision, and predict the likely outcomes of each action before they occur. When comparing the common definition of AI as the capability of a machine to imitate intelligent human behavior with the Turing Test challenge of creating an algorithm that performs a task indistinguishably from a human counterpart, it becomes clear that machines are still in the process of evolving. However, there are a few examples of use cases in health care that are coming closer to realizing the Turing Test.

STATUS OF HEALTH CARE AI

Some of the most promising use cases for health care AI tools include predictive analytics, precision medicine, and clinical decision support. Development in all of these areas is already well underway. The private sector has acknowledged these opportunities, and investments in AI have grown over the past several years. A recent report from Markets and Markets pins the health care AI sector at nearly $8 billion in 2022, accelerating at a compound annual growth rate of 52.68 percent over the forecast period.

In 2011, IBM got an early start in the health care AI space by using Watson’s NLP and cognitive computing abilities to train in clinical decision support at some of the top medical institutions in the country. IBM has also committed extensive resources, such as its $2.6 billion acquisition of Truven, to imaging analytics, genomics, pharmaceuticals, and population health management. Their efforts are not without roadblocks—a multiyear project to apply IBM Watson to cancer diagnostics with MD Anderson ended in failure. Other industry leaders, Google and Microsoft, are ramping up their efforts to apply advanced machine learning algorithms to the mysteries of human biology. Microsoft is tackling genomics, cancer, myopia and blindness, transplants, and imaging analytics, while Google recently published research on the role of machine learning in pathology and breast cancer, and diabetic retinopathy. Additionally, Google is the first of the titans to establish a formal program, Launchpad Studio, for working with startups specific to the industry, such as Augmedix, BrainQ, Byteflies, and Cytovale.

Currently, machine learning has started to prove its value in the realm of pattern recognition, NLP, and deep learning. At the Stanford University School of Medicine, a machine-learning algorithm out-performed pathologists at predicting patient survival times for two types of lung cancer. In the United Kingdom, a NLP tool applied to free-text peer assessments of physician performance, derived by human raters, agreed with the content of the documents 98 percent of the time. At Indiana University-Purdue University Indianapolis, machine learning correctly predicted relapse rates for a type of leukemia 90 percent of the time. It identified patients who would experience remission with 100 percent accuracy. Engineers at Boston University are working with Brigham and Women’s Hospital, and Boston Medical center to manage heart diseases and diabetes using
algorithms that have the ability to predict hospitalizations up to a year in advance with 82 percent accuracy. However, current algorithms do not result in autonomous decisions. Instead, they play an assistive role to augment human intelligence rather than replace it.

FUTURE OF AI IN MEDICINE

What does the future of AI hold in medicine? AI technology could change the world for the better by making care delivery safer, improving diagnostic accuracy, increasing physician productivity and scale, or contributing to applications that improve quality of life. As the technology of AI continues to develop, physicians and medical associations must ensure that AI-enabled systems are governable; are open, transparent, and understandable; can work effectively with people; are included in medical education for students and practicing physicians; and remain consistent with human and medical ethics. Physician involvement with the evolution of this active field may help them to chart a better and wiser path forward for themselves, their patients, and the health care system.

Opportunities and challenges of AI in health care are equally profound for physicians:

**Opportunities**

- Office and hospital automation – patient scheduling, order entry, chat bots, voice recognition, etc.
- Data mining to surface the right data at the right time, and improve EHRs
- Diagnosis – analyze all the known data about the patient and produce insights
- Treatment – analyze the diagnosis and all other known data and produce best practice treatments, perhaps even comparing to “patients like me” data
- Additional time for physicians to spend with patients to focus on their health
- Improve patient experience, and aid behavioral change and treatment compliance
- Medical education – personal assistant for students and residents to surface information (less memorization), automated continuous assessment of competencies, and coaching

**Challenges**

- Data structure, integrity and security
- Technological mistrust – transparency is key
- Demonstrate that AI can reduce costs, deliver the quadruple aim, support the patient-physician relationship, and/or alleviate administrative burden
- Implement and integrate AI into clinical practices and patient care
- Uncertain long term employment outlook for health care professionals
- Susceptibility to training bias, malfeasance, and other possible technical problems
- Questions as to who will benefit and who may lose—what is best for an individual is not always best for public health, especially when limited resources are available

Additionally, AI opportunities and challenges lead to questions physicians will need to confront:

- What evidence is needed to demonstrate value, utility, and trust?
- How does AI intersect with other emerging health care capabilities, such as genomic medicine?
- How will regulatory bodies and professional organizations provide proper oversight for AI benefits and risks, and communicate these to the public?
- How can public and systemic expectations be managed, and concerns allayed?
• What education and training will health care professionals need to acquire in order to understand how AI solutions might help them, and their patients in clinical settings?

• What can health systems considering AI opportunities do now to maximize their chances of success for gaining efficiencies, improving care, and integrating into clinical workflows?

• How will risk be allocated, given the “black box” nature of AI systems?

• How will legal, policy, and regulatory implications, including standards for professional services, intellectual property rights, and FDA oversight be monitored and addressed?

Beyond the potential to dramatically affect the economy and society in the near future, AI has moved to the forefront of many policy debates around the world. These debates range from the governance of AI, such as ensuring accountability of algorithmic decisions, to mitigating the impact of AI on employment. Clear challenges must be addressed to support AI’s future in medicine. Therefore, it is up to all stakeholders, be they health care professionals, medical associations, policymakers, businesses, the technology industry, or civil society to ensure that AI’s impact is a positive one by proactively tackling the challenges, while ensuring the opportunities remain available.

REFERENCES

5 MarketsandMarkets. Artificial Intelligence in Healthcare Market by Offering (Hardware, Software and Services), Technology (Deep Learning, Querying Method, NLP, and Context Aware Processing), Application, End-User Industry, and Geography – Global Forecast to 2022. https://www.marketsandmarkets.com/Market-Reports/artificial-intelligence-healthcare-market-54679303.html?gclid=CiwKCAiAr_TXBRB5EiwACQCq3mVid0-a0Lo3XVAu-TwQC4n8H5xUr56q9B65KYT2JWLpWlANlOVC6vQQAvD_BwE.
Subject: Study of Declining Native American Medical Student Enrollment

Presented by: Lynne Kirk, MD, Chair

American Medical Association (AMA) Policy D-200.985 (5), “Strategies for Enhancing Diversity in the Physician Workforce,” reads as follows:

5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

This section of the policy was appended through Resolution 313-A-17, “Study of Declining Native American Medical Student Enrollment,” which was introduced by the AMA Minority Affairs Section at the 2017 Annual Meeting of the AMA House of Delegates (HOD).

Testimony before Reference Committee C during the meeting reflected limited but supportive testimony on this item focused on the need for increased diversity of the physician workforce to support access to patient care among underserved populations. It was noted that existing AMA policy on diversity dovetails with the intent of this resolution, and that the decline in the number of Native Americans entering medical school is worrisome and may hold future negative ramifications for access to care. Accordingly, Reference Committee C recommended adoption of Resolution 313 to the HOD, and the HOD accepted this recommendation. This report is in response to this policy.

BACKGROUND

The concern regarding Native American student enrollment and the Native American physician workforce is supported by Native American population health outcomes data, Native American health care accessibility data, student enrollment data, workforce data, and the quest for a culturally diverse and culturally competent physician workforce able to meet the health care needs of people from all ethnic backgrounds. The estimated 5.2 million American Indians and Alaska Natives (AI/ANs) living in the U.S. have long experienced lower health status when compared with other Americans. Between 1999 and 2014, premature mortality rates increased for AI/AN populations, while decreasing for blacks, Hispanics, Asians, and Pacific Islanders during the same period. The rates are particularly high for young adult AI/AN individuals. Lack of access to health care and mental health resources is believed to be a causative factor. Lower life expectancy and a disproportionate disease burden exist for a variety of reasons, including inadequate education, lack of economic development and investment, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions. Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of AI/AN deaths (2008-2010). AI/AN
individuals born today have a life expectancy 4.4 years shorter than the U.S. population as a whole\textsuperscript{2} and seven years shorter than non-Hispanic whites.\textsuperscript{3} In a 2016 U.S. Government Accountability Office report to Congress, difficulties in filling health care provider vacancies and long wait times for primary care appointments were noted to be contributing factors to the health care disparities facing AI/ANs.\textsuperscript{4} A survey by the Harvard School of Public Health found that 23\% of AI/ANs surveyed experienced discrimination when seeking health care, and 15\% avoided seeking healthcare for themselves or their family because of concern that they would be discriminated against.\textsuperscript{5}

The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, states there is “ample opportunity—and pressing need—for physicians practicing a wide range of specializations.” The IHS website lists numerous job openings across multiple medical specialties and geographic locations.\textsuperscript{6} Federal law requires that absolute preference be given to AI/AN applicants. Out of the total active MD workforce (approximately 850,000) in the U.S., 0.4\% (3,400) are self-identified as AI/AN.\textsuperscript{7}

In addition to the positive impact on the educational environment through, for example—(1) cultural competence in care delivery; (2) intellectual benefits; and (3) interpersonal benefits for patients, learners and faculty—increasing AI/AN medical school enrollment would translate into an increase in the AI/AN physician workforce. A workforce increase of this nature could positively impact AI/AN population health and improve access to physician services. A report from the Health Resources and Services Administration on physician workforce characteristics found that minority physicians have a greater propensity to practice in physician shortage areas (although the report did not specifically address AI/AN physicians or the AI/AN population).\textsuperscript{9} Another review on this subject concluded that underrepresented minority health professionals have been consistently more likely to deliver health care to the underserved; this study did include AI/AN providers but did not specifically address AI/AN physicians in the findings or conclusions.\textsuperscript{10} There are few conclusive data demonstrating that increasing the number of AI/AN medical students (and ultimately AI/AN physicians) would result in increased numbers of physicians who serve AI/AN communities. A literature search uncovered only one study, published in 1989, which concluded that most AI/AN physicians, while residing in areas with significant AI/AN populations, were primarily serving non-AI/AN patient populations.\textsuperscript{11} Collecting data on AI/AN physician practice patterns has proven difficult for a number of reasons, including the organization of providers to serve AI/AN needs. The Indian Self Determination and Education Assistance Act, also known as Public Law 93-638, allows the IHS to provide funds directly to tribes for administration and delivery of health services.\textsuperscript{12} An unintended consequence of this law has been to make collection of provider data difficult. A comprehensive study is currently underway to determine the practice setting and populations served by AI/AN physicians (personal communication with the study author, Siobhan Wescott, February 22, 2018).

When considering the available information on this topic, it is important to note that most data on AI/AN medical student enrollment and the physician workforce rely on an individual’s self-identification as American Indian, Native American, or Alaska Native. There is no established definition of AI/AN. The U.S. government relies on each of the 567 recognized tribes to set the standards for inclusion as a member of the tribe and official status of AI/AN or Native American.\textsuperscript{13} Inconsistency in criteria for recognition of AI/AN status may result in inaccuracies and inconsistencies in data. Some data sources also allow individuals to self-identify as “multiple race/ethnicity,” which may lead to underreporting of AI/AN data.
Among the ethnic groups traditionally considered to be underrepresented in medicine, AI/AN ethnicity is the least represented among U.S. allopathic medical students. Data from the Association of American Medical Colleges (AAMC) show that in 2016 a total of 20 schools reported at least one applicant who self-identified as AI/AN. The percentage of AI/AN applicants to these schools ranged from 0.9% to 3.8% of the total applicant pool. AAMC enrollment data for academic year 2016-17 show that 223 students, or 0.25% of the total allopathic medical school enrollees, self-identified as AI/AN. The majority of these students were enrolled in medical schools in Oklahoma (20), New Mexico (17), Minnesota (17), Texas (16), North Dakota (15), and Arizona (10). For the allopathic medical school graduating class of 2016, 31 individuals, or 0.16%, self-identified as AI/AN. Since 2002, the number of AI/AN applicants and matriculants to allopathic medical schools has been relatively consistent, despite the increase in the overall number of applicants and enrollees.

Data for osteopathic medical schools show that in 2016, a total of 51 applicants, or 0.3%, self-identified as AI/AN. Over the last 15 years, the number of AI/AN applicants to osteopathic schools has remained relatively constant (between 38 to 69 annually). Nine AI/AN students, or 0.1% of the total enrollee pool, matriculated into osteopathic schools in 2016. Data were not available for AI/AN enrollment in individual osteopathic medical schools in 2016, but the greatest numbers of applications were to schools located in Arizona (31), Pennsylvania (32) and Oklahoma (29). These data likely include students who applied to multiple programs.

Data regarding allopathic and osteopathic AI/AN applicants and enrollment are shown in the table at the end of this report. There are no data on the number of AI/AN applicants who applied to both allopathic and osteopathic programs. Of note, while both the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation have standards requiring medical schools to achieve diversity in enrollment, the standards do not specify what groups the schools must include in their respective definitions of diversity and efforts to achieve diversity outcomes.

Although the absolute numbers of applicants and matriculants, albeit small, have remained relatively constant over the last 15 years, the growth in total medical school applications and enrollment has resulted in a declining percentage of AI/AN applicants and matriculating students. This has occurred despite the emphasis on increasing diversity in matriculants to medical school and the physician workforce; an acceptance rate for AI/AN (44.9%) that exceeds all other racial and ethnic groups, including whites; and increases in the applicant and matriculation rates for other groups traditionally identified as underrepresented in medicine. These data indicate that efforts to recruit AI/AN students to enter health professions education are inadequate.

MEDICAL SCHOOL AND HEALTH PROFESSIONS PROGRAMS TO SUPPORT AI/AN ENTRY INTO HEALTH CARE CAREERS

The relative decline in AI/AN applicants and matriculants has occurred despite focused efforts by institutions in states with large AI/AN populations. Several medical schools, alone or in collaboration with other schools, have implemented programs to encourage and support AI/AN students into the health professions.

For example, the North Dakota School of Medicine and Health Sciences has developed the Indians Into Medicine Program (INMED™), a comprehensive program designed to assist American Indian students who aspire to be health professionals and to meet the needs of tribal communities.
Established in 1973, the program aims to address three major problems: 1) too few health professionals in AI communities, 2) too few AI health professionals, and 3) the substandard level of health and health care in AI communities. INMED support services include academic and personal counseling for students, assistance with financial aid applications, and summer enrichment sessions at the junior high through professional school levels. Each year, more than 100 AI students attend INMED’s annual summer enrichment sessions at the junior high, high school, and medical preparatory levels. These summer programs bolster participants’ math and science backgrounds and introduce them to health careers.

The state of Oklahoma is home to two medical schools as well as a significant AI population. The University of Oklahoma supports a summer enrichment program which aims to identify and support minority students, including AI students, who aspire to enter medical school. In 2014 the Oklahoma State University Center for Health Sciences, which houses the Oklahoma State University College of Osteopathic Medicine (OSUCOM), launched an Office for the Advancement of American Indians in Medicine and Science (OAAIMS) to recruit more American Indian high school and college students into medicine and science careers. Through mentoring and targeted programs, the initiative aims to increase the number of American Indians practicing medicine and working in the science fields. Ultimately, efforts made by the OAAIMS are intended to provide Native American students the means to be successful in these fields by offering hands-on experiences that combine Native culture, medicine, and science. Programs include a culturally-based scientific expedition experience for high school students, residential camps with simulation exercises, and a number of outreach programs on-site with tribal partnerships. These focused efforts have been effective, as OSUCOM’s latest incoming class of 2017 included 17 students who self-identified as AI/AN.

The University of Minnesota Medical School (UMMS) founded its Duluth campus in 1972 specifically for the purpose of serving the needs of rural Minnesota and Native American communities and to be a national leader in improving health care access and outcomes in rural Minnesota and AI/AN communities. The UMMS also launched the Center for American Indian and Minority Health in 1987. The purpose of the Center is to raise the health status of American Indians and Alaska Natives by: 1) recruiting and educating Native American medical students, 2) increasing awareness of American Indian health care issues, and 3) conducting research that serves the health interests of Native American communities.

Five medical schools in the southwest—the Universities of Arizona (Phoenix and Tucson), Colorado, New Mexico, and Utah—identified a collective need to increase student diversity, particularly with regard to AI/AN students. These five schools created the “4 Corners Alliance,” and, in collaboration with the Association of American Indian Physicians, invite pre-med/health American Indian students to a free two-day Pre-Admissions Workshop (PAW) annually. The PAW aims to provide students with the information and skills necessary to succeed in the medical and health professions school admission process.

Medical schools also have developed programs to address AI/AN health. For example, the University of Washington School of Medicine offers an Indian Health Pathways Certificate Program for medical students. The program’s goals are to: 1) prepare both native and non-native medical students for careers in AI/AN health, 2) encourage research on AI/AN health issues, and 3) enhance curriculum on AI/AN health issues at the University of Washington School of Medicine.

On a national level, the IHS supports AI/AN entry into the health professions and opportunities to explore career paths in AI/AN health care. Scholarships are available through the IHS Scholarship program, which has awarded more than 7,000 health professions scholarships since 1978. The IHS
website provides links to allow potential students to arrange IHS externships (with salary), and to
cordinate AI/AN clerkship opportunities for medical students. In addition, post-graduation
financial support is available through the IHS, with a loan repayment program of $20,000 per year
of commitment (maximum $40,000) for health professions education loans, as well as a
supplemental loan repayment program. The IHS also participates in the National Health Service
Corps loan repayment program, with awards up to $50,000 for a two-year commitment.26

The University of Wisconsin, in collaboration with tribal organizations in Wisconsin and the Great
Lakes Region, supports an outreach program, We are Healers, which aims to inspire AI youth to
envision themselves as health professionals through stories of Native role models.27

Two organizations specifically provide support for AI/AN students aspiring to become physicians:
the Association of American Indian Physicians (AAIP) and the Association of Native American
Medical Students (ANAMS). The AAIP, whose mission includes promoting education in the
medical disciplines, supports workshops, summer programs, scholarship programs, internships, and
fellowships aimed at increasing the number of AI/AN students entering the health professions.28
The ANAMS, whose mission is to assist with the recruitment, retention, and support of AI/AN
students into medicine and other health careers, provides information on a number of scholarship
opportunities available to AI/AN students.29

The causes of the declining percentages of applicants and matriculants are not clear, but in part
may be explained by the pre-secondary education success of and college education opportunities
for AI/AN students. AI/AN students have the highest high school dropout rates among all racial
and ethnic groups tracked by the National Center for Educational Statistics (NCES).30 Additionally,
the college enrollment rate (23%) for AI/AN 18- to 24-year-olds is the lowest of all ethnic and
racial groups tracked by the NCES.31 A recent survey of AI/ANs found that for almost half of
respondents, college attendance was never discussed during adolescence and young adulthood.3
Overall, the AI/AN college graduation rate of 9.3% is well below the national average of 20.3%.
The relative ineffectiveness of health professions pipeline programs for AI/AN has been described
in the literature, possibly attributable to less rigor in primary and secondary education in science
and mathematics.32

RELEVANT AMA POLICY AND ACTIVITIES

A list of relevant AMA policies on this issue is shown in the appendix. These include:

- D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce”
- H-350.970, “Diversity in Medical Education”
- H-350.979, “Increase the Representation of Minority and Economically Disadvantaged
  Populations in the Medical Profession”
- H-350.960, “Underrepresented Student Access to US Medical Schools”

Aside from policy, since 2002 the AMA has supported the Doctors Back to School™ (DBTS),
designed by the AMA Minority Affairs Consortium (today the Minority Affairs Section, or MAS)
to highlight the need to expand the pipeline of underrepresented minorities (i.e., black, Latino,
Native American) in medicine and eliminate minority health disparities. Through DBTS,
physicians and medical students return to their communities to 1) pique young minority students’
interest in medicine by introducing them to “real-life” role models and 2) raise awareness of the
need for more underrepresented minorities in the physician workforce. To date, DBTS has engaged
more than 100,000 underrepresented minority youth. To expand the reach of the program and
number of volunteers, the MAS has developed partnerships with other AMA sections (e.g., Medical Student Section); medical societies/associations (e.g., American Society of Anesthesiologists; Association of American Medical Colleges); coalitions (e.g., Commission to End Health Care Disparities); nonprofit organizations (e.g., National Minority Quality Forum), and diversity pipeline programs in medicine (e.g., Tour for Diversity; Mentoring in Medicine).

Each year, the MAS also partners with the AMA Foundation’s Physicians of Tomorrow scholarship program to offer the Minority Scholars Award to underrepresented minority medical students, with $10,000 awards toward their tuition expenses. Up to two students can be nominated by each medical school dean. In recent years, awards have been disbursed to 20-25 recipients annually. Since the inception of the program in 2004, 11 recipients have self-identified as Native Alaskans.

SUMMARY

Despite the current level of support, outreach, and pipeline programs as noted above, the number of AI/AN applicants/matriculants to medical schools remains quite low and essentially unchanged over the last 15 years, even as the total enrollment in U.S. medical schools has markedly increased.

Although AI/AN students who are able to succeed in pre-medical training have ample opportunity and high rates of success in gaining entry into medical schools, the current primary and secondary education infrastructure and socioeconomic factors for AI/AN students may be inadequate to promote successful entry in larger numbers into college-level education. While health professions pipeline programs to promote AI/AN entry are in place at a number of institutions, and these programs are showing success at the local level to promote medicine as a career path for AI/AN students, they are limited in size and scope and have not been successful to date in increasing AI/AN diversity in overall medical school enrollment or the physician workforce. Future initiatives might benefit from focused efforts to improve preparation of AI/AN students for entry into post-secondary education, particularly in the areas of science and mathematics.
TABLE: AI/AN APPLICANTS AND ENROLLMENT AT U.S. ALLOPATHIC AND OSTEOPATHIC MEDICAL SCHOOLS

<table>
<thead>
<tr>
<th>Year</th>
<th>Allopathic medical schools</th>
<th>Osteopathic medical schools</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AI/AN applicants</td>
<td>AI/AN matriculants</td>
</tr>
<tr>
<td>16-17</td>
<td>127</td>
<td>54</td>
</tr>
<tr>
<td>15-16</td>
<td>115</td>
<td>55</td>
</tr>
<tr>
<td>14-15</td>
<td>117</td>
<td>53</td>
</tr>
<tr>
<td>13-14</td>
<td>110</td>
<td>43</td>
</tr>
<tr>
<td>12-13</td>
<td>108</td>
<td>52</td>
</tr>
<tr>
<td>11-12</td>
<td>101</td>
<td>46</td>
</tr>
<tr>
<td>10-11</td>
<td>114</td>
<td>55</td>
</tr>
<tr>
<td>09-10</td>
<td>111</td>
<td>51</td>
</tr>
<tr>
<td>08-09</td>
<td>131</td>
<td>66</td>
</tr>
<tr>
<td>07-08</td>
<td>152</td>
<td>67</td>
</tr>
<tr>
<td>06-07</td>
<td>147</td>
<td>70</td>
</tr>
<tr>
<td>05-06</td>
<td>95</td>
<td>38</td>
</tr>
<tr>
<td>04-05</td>
<td>107</td>
<td>53</td>
</tr>
<tr>
<td>03-04</td>
<td>85</td>
<td>38</td>
</tr>
<tr>
<td>02-03</td>
<td>112</td>
<td>56</td>
</tr>
</tbody>
</table>

Allopathic data extracted from data tables found on the AAMC website, unless otherwise noted.

Osteopathic data extracted from data tables found on the AACOM website.

* Data from Barzansky B, Etzel S. Medical Schools in the United States, *JAMA* annual data publications. Data are for first year enrollment, not matriculants.
APPENDIX: RELEVANT AMA POLICY

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.
6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

H-350.970, “Diversity in Medical Education”
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide
education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.

H-350.979, “Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession”
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and pre-collegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school. (CLRDPD Rep. 3, I-98 Reaffirmed: CLRDPD Rep. 1, A-08)

H-350.960, “Underrepresented Student Access to US Medical Schools”
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students. (Res. 908, I-08 Reaffirmed in lieu of Res. 311, A-15)
REFERENCES

22 Shrum K, Vuong A. Summary of American Indian Physician Pipeline Program at OSU-COM. Report distributed at Oklahoma State University Center for Health Sciences. September 18, 2017; Tulsa, OK.
Subject: Addressing the Site-of-Service Differential
(Resolution 817-I-17)

Presented by: Paul A. Wertsch, MD, Chair

At the 2017 Interim Meeting, the House of Delegates referred Resolution 817, “Addressing the Site of Service Differential,” which was introduced by the New Mexico Delegation and assigned to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting. Resolution 817-I-17 asked:

That our American Medical Association (AMA) study the site-of-service differential with a report back no later than the 2018 Interim Meeting, including: a) the rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements; b) the increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance; c) the expense of maintaining hospital based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs; and d) the methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges; and

That our AMA advocate for a combined Health Care Payment System for patients who receive care that is paid for by the Centers for Medicare & Medicaid Services, that: a) follows the recommendation of MedPAC to pay “site-neutral” reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (HOPPS) or the Physician Fee Schedule (PFS); b) pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and c) provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices.

Resolution 817-I-17 raised a number of complex cost and payment issues spanning several subject matter areas in need of extensive study. These issues are further complicated by the Medicare program’s use of separate payment methodologies for each outpatient setting (ie, physician offices, hospital outpatient facilities, and ambulatory surgical centers). A current AMA Issue Brief provides an overview of these payment variations. The Council supports payment policies that are site-neutral to the extent possible without lowering payments overall and that fairly reflect the actual costs of providing services. AMA policy supporting equitable payments across outpatient sites of service, including policy established via Council reports, is appended. The Council recognizes the need for further study, and its deliberations of options for achieving payment parity under the Medicare program are ongoing. Accordingly, the Council intends to submit its final report with recommendations addressing the site-of-service differential at the 2018 Interim Meeting.
Appendix

**H-240.979 Intrusion by Hospitals into the Private Practice of Medicine**
The AMA urges private third party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently-owned outpatient facilities with respect to payment of “facility” costs. (CMS Rep. H, I-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: Res. 116, A-14; Reaffirmation A-14; Reaffirmation A-15)

**H-240.993 Discontinuance of Federal Funding for Ambulatory Care Centers**
The AMA strongly urges more aggressive implementation by HHS of existing provisions in federal legislation calling for equity of reimbursement between services provided by hospitals on an outpatient basis and similar services in physicians’ offices. (CMS Rep. B, A-83; Reaffirmed: CLRDPD Rep. 1, I-93; Reaffirmation I-98; Reaffirmation I-03; Reaffirmation I-07; Reaffirmed: CMS Rep. 3, A-13; Reaffirmation A-15)

**D-240.994 Payment Variations Across Outpatient Sites of Service**
Our AMA will work with states to Advocate that third party payers be required to: a. Assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility); b. Publish and routinely update pertinent information related to patient cost-sharing; and c. Allow their plan’s participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. (CMS Rep. 3, A-13; Reaffirmation I-17)

**H-330.925 Appropriate Payment Level Differences by Place and Type of Service**
Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. (Sub. Res. 104, A-98; Reaffirmation I-98; appended: CMS Rep. 7, A-99; Reaffirmation A-00; Reaffirmation I-03; Reaffirmation A-11; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed: Sub. Res. 104, A-14; Reaffirmed: Res. 116, A-14; Modified: CMS Rep. 3, A-14; Reaffirmation A-14; Reaffirmation A-15; Reaffirmation I-17)

**D-330.997 Appropriate Payment Level Differences by Place and Type of Service**
1. Our AMA encourages CMS to: (A) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (B) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers. 2. Our AMA will continue to encourage the CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments. (CMS Rep. 7, A-99; Reaffirmation I-03; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed: CMS Rep. 4, A-13; Appendix: CMS Rep. 3, A-14; Reaffirmed: Sub. Res. 104, A-14; Reaffirmation A-14; Reaffirmation A-15; Reaffirmation I-17)
D-390.997 CMS Practice Expense Formula
Our AMA will seek from Congress legislation directing CMS that it include in the RBRVS practice expense allocation all costs incurred by physicians, including those costs incurred in hospitals and ambulatory surgical centers. (Sub. Res. 819, I-99 Reaffirmed: CMS Rep. 5, A-09)

H-400.957 Medicare Reimbursement of Office-Based Procedures
Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmation A-04 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 3, A-14)

H-400.966 Medicare Payment Schedule Conversion Factor
(1) The AMA will aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) The AMA will work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index. (CMS Rep. B, I-92 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CMS Rep. 6, I-08 Reaffirmed: CMS Rep. 1, I-11 Reaffirmation: I-12 Reaffirmed in lieu of Res. 113, A-13 Reaffirmation I-13 Reaffirmed: CMS Rep. 3, A-14)

H-400.956 RBRVS Development
(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians. (BOT Rep. 16, A-95 BOT Rep. 11, A-96 Reaffirmed: CMS Rep. 4, I-02 Reaffirmed: BOT Rep. 14, A-08 Reaffirmed: Sub. Res. 104, A-14 Reaffirmation A-15)

H-400.969 RVS Updating
Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3)

D-478.996 Information Technology Standards and Costs

1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. 2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation I-17)
REPORT OF THE SPEAKERS

Speakers’ Report 1-A-18

Subject: Recommendations for Policy Reconciliation

Presented by: Susan R. Bailey, MD, Speaker
Bruce A. Scott, MD, Vice Speaker

Policy G-600.111, “Consolidation and Reconciliation of AMA Policy,” calls on your Speakers to “present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete.”

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken in 2017. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to language will be made, additions are shown with underscore and deletions are shown with red strikethrough.

RECOMMENDED RECONCILIATIONS

Policy to be modified in light of later House of Delegates action


This policy requires a minor change in the first paragraph given that the House amended the bylaws and adopted policy to implement the new procedure for apportioning delegates to national medical specialty societies. The change is a modest deletion from the policy and includes an appropriate capitalization in the first sentence. No other change to the policy is necessary.

1. The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and s Specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request.…

Policy to be modified for clarification and consistency with practice

II. G-600.061, “Guidelines for Drafting a Resolution or Report”

The title of Policy G-600.061, “Guidelines for Drafting a Resolution or Report,” suggests that it applies to both resolutions and reports, and in fact several parts of the policy refer specifically to both resolutions and reports. However, some subparagraphs of Paragraph 1 do not reference reports, despite the fact that practice has enforced the guidelines with respect to all reports submitted to the House, and the House of Delegates Reference Manual plainly states (page 30) that...
a fiscal note “indicating the financial implications of the report’s recommendations” will be
included. To ensure correspondence between the policy title and actual practice, the policy should
explicitly address reports in Paragraphs 1, 1b, 1c and 1d.

G-600.061, Guidelines for Drafting a Resolution or Report

Resolutions or reports with recommendations to the AMA House of Delegates shall meet the
following guidelines:

1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:

   a. The proposed policy should be stated as a broad guiding principle that sets forth the
general philosophy of the Association on specific issues of concern to the medical
profession;

   b. The proposed policy should be clearly identified at the end of the resolution or report;

   c. Recommendations for new or modified policy should include existing policy related to
the subject as an appendix provided by the sponsor and supplemented as necessary by
AMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline;

   d. A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA’s elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution or report is estimated to have a resource implication of $50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.

2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.

3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.

4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a
recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.

5. The House’s action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the “revised” or “corrected” report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.

6. All resolutions and reports should be written to include both “MD and DO,” unless specifically applicable to one or the other.

7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.

8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:
   a. New HOD Policy;
   b. Modify Current HOD Policy;
   c. Consolidate Existing HOD Policy;
   d. Modify Bylaws;
   e. Rescind HOD Policy;
   f. Reaffirm HOD Policy; or
   g. Directive to Take Action.

9. Our AMA’s Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.

References to completed reports to be deleted from policies

The following policies will be modified by deleting references to requested reports that have been sent to and considered by the House of Delegates. Other, substantive portions of these directives are unchanged.

III. H-95.990, “Drug Abuse Related to Prescribing Practices”

The policy includes a request for a study that has been completed, so that section of the policy will be stricken. The remainder of the policy remains intact.

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
   A. institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse
problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.

B. placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:
   A. promotes physician training and competence on the proper use of controlled substances;
   B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
   C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
   D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.

4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.

Council on Science and Public Health Report 2-I-13, “A Contemporary View of National Drug Control Policy,” reviewed the material and addressed the elements of paragraph 3 within the Council’s expertise. For that reason, paragraph 3 will be deleted.

IV. D-160.927, “Risk Adjustment Refinement in ACO Settings and Medicare Shared Savings Programs”

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

At the 2017 Annual Meeting, the Board of Trustees offered Report 21, “Risk Adjustment Refinement in Accountable Care Organization (ACO) Settings and Medicare Shared Savings Programs (MSSP),” which described efforts that had been undertaken to address the CMS policies...
and noted that our AMA would continue to urge CMS to improve risk adjustment methodology in ACOs.

V. D-165.935, “Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care”

1. Our AMA will: (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.

2. Our AMA Board of Trustees will report back to our AMA House of Delegates at the 2017 Annual Meeting.

BOT Report 24-A-17, “Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care,” characterized the efforts that had been undertaken to that point, including engagement with the Federation, collaborations with various patient advocacy groups and letters to congressional leadership as well as the White House.

VI. D-478.970, Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging

Our AMA: (1) will study the medicolegal implications of text messaging and other non-HIPAA-compliant electronic messaging between physicians, patients, and members of the health care team, with report back at the 2017 Annual Meeting; and 2) will develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients, and members of the health care team.


Policy with a title change

VII. D-478.964, “High Cost to Authors for Open Source Peer Reviewed Publications”

Following usual practice, Board of Trustees Report 10-I-17 took its title from the underlying referred resolution. While the body of the report correctly referred to open access journals, the title, taken directly from the resolution, employed the term “open source.” As “open access” is the preferred terminology, the title of Policy D-478.964 will be changed to “High Cost to Authors for Open Access Peer Reviewed Publications.”

Directives to be rescinded in full

The following directives will be rescinded in full, as the requested studies have been completed, with reports presented to the House of Delegates several years ago.
VIII. D-160.930, “Studying Physician Access to ACO Participation”

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

The directive was fulfilled by Council on Medical Service Report 7-A-15, “Physician Access to ACO Participation,” which noted that efforts to identify and support current and emerging payment and care delivery models that work best for physicians across a variety of practice settings are ongoing.

IX. D-165.940, “Monitoring the Affordable Care Act”

Our AMA will assess the progress of implementation of the Patient Protection and Affordable Care Act based on AMA policy, as well as the estimated budgetary, coverage and physician-practice impacts of the law, and report back to the House of Delegates at the 2013 Interim Meeting.

Council on Medical Service Report 5-I-13, “Monitoring the Affordable Care Act,” was prepared in response to this directive.

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

Fiscal note: $250 to edit policy database.
When in-flight medical emergencies occur on commercial airlines, medical personnel who may be onboard are typically called upon to assist. It is estimated that medical emergencies occur on 1 in every 604 flights. This is likely an underestimate, however, since many medical events are handled on board without the service of ground-based consultation centers. The likelihood of a physician being on board a flight when a medical emergency occurs is much higher, at nearly 50 percent, and 42 percent of physicians have reported being asked to volunteer during a flight.

Many physicians, however, are unsure about what to do during in-flight emergencies. There are currently no guidelines for volunteer medical professionals to manage ill passengers during commercial flights, and “emergency medical kits” are not mandated by any international body. Physicians may be unsure of what to do during in-flight emergencies, and do not know what resources are available to them.

In 2014, at the urging of the Illinois State Medical Society (ISMS), the American Medical Association (AMA) adopted a resolution calling on the AMA to “support and participate in efforts to educate the flying physician public about in-flight emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs.”

Raymond Bertino, M.D., a member of our AMA and the ISMS, has developed a free smartphone app – airRx – that offers instructions on how to handle in-flight emergencies until the patient can be given more comprehensive care on the ground. Dr. Bertino developed the app with other physicians, including two emergency medicine specialists who have specific experience in aerospace medicine, and they are proud to make the app available at no cost.

Members of our AMA are encouraged to download and make use of the airRx app if called on to volunteer during an in-flight emergency.

The app is designed to work in “airplane mode” without wireless internet access or access to cellular data, and is currently the only app designed by and for medical personnel encountering in-flight medical events while traveling on commercial airlines. (Over)
Content on the app includes instructions on how to handle the 23 most common medical emergency scenarios encountered, which include syncope, gastrointestinal upset, respiratory symptoms, chest pain, and cardiovascular events (which frequently result in diversion of the flight). The app also covers information on what medications and equipment are available on flights, based on the airline carrier and its national origin.

Search “airRx” in your preferred app store to download the airRx app to your phone or tablet.

Screenshots:

www.airrxmedical.com

*This item is an “information statement.” An information statement may be submitted to bring an issue to the attention of the HOD. The item will be included as an informational item but will not go to a reference committee or be acted upon in any way by the House, unless extracted.