Whereas, The AMA has guidelines that expect all institutions to provide retirement benefits; and

Whereas, With resident and fellowship matching, physicians do not have choice in the benefit package causing differences in retirement outcomes; and

Whereas, Physicians should be saving 15% of their funding towards retirements, but studies have shown that physicians have not been saving enough due to multiple reason including significant student debt, delayed start in professional life, and decreased financial literacy1,2,3; and

Whereas, Evidence has shown that employers who match retirement savings, result in employees saving significantly more annual for retirement4; therefore be it

RESOLVED, That our American Medical Association support retirement plans for all residents and fellows, which includes retirement plan matching in order to further secure the financial stability of physicians and increase financial literacy during training (New HOD Policy); and be it further

RESOLVED, That our AMA support that all programs provide financial advising to resident and fellows. (New HOD Policy)

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

Received: 09/06/17
Whereas, On May 11, 2018, President Donald Trump announced a new proposal to lower
prescription drug prices that includes potential for future reforms to the 340B Drug Discount
Program (340B program); and

Whereas, The 340B program is intended to increase access to care for indigent patients; and

Whereas, Participation in the 340B program has grown exponentially, far beyond its initial
intended scope; and

Whereas, There is insufficient data collection to ensure that the 340B program is benefiting all
vulnerable patients in the intended populations to the fullest extent possible; and

Whereas, Recent Medicare Hospital Outpatient Prospective Payment System (HOPPS) rule
changes reduced reimbursement rates for 340B eligible institutions without consideration for
impact on patient access or additional program reforms; and

Whereas, There has been inadequate emphasis on identifying and responding to adverse
impacts that the 340B program may have on patient access to high-quality, high-value care
provided through the availability of community-based physician practices; and

Whereas, Community-based physician practices have been recognized as providing cost-
effective access points for the care of vulnerable individuals with cancer, but outpatient
oncology practices cannot currently qualify as standalone entities under the 340B Drug Pricing
program; therefore be it

RESOLVED, That our American Medical Association advocate for 340B Drug Discount Program
(340B program) transparency, including an accounting of covered entities’ 340B savings and
the percentage of 340B savings used directly to care for underinsured patients and patients
living on low-incomes (New HOD Policy); and be it further

RESOLVED, That our AMA support recommendations to equip the Health Resources and
Services Administration (HRSA) with more authority, resources and staff to conduct needed
340B program oversight (New HOD Policy); and be it further

RESOLVED, That our AMA support discontinuing the use of the Disproportionate Share
Hospital adjustment as a determining measure for 340B program eligibility (New HOD Policy); and be it further
RESOLVED, That our AMA recognize the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients. (New HOD Policy)

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

Received: 06/05/18
Whereas, Civil pilot health is a significant public health concern; and
Whereas, Proper and correct clearance for pilots to fly requires careful assessment of physical status and the potential effects of medications; and
Whereas, The complex interactions of medications and underlying health conditions involving multiple bodily systems are compounded at high altitudes; and
Whereas, The 2015 update to Federal Aviation Administration (FAA) statutes creates a new category for civil pilot health monitoring known as BasicMed; and
Whereas BasicMed requires examination by a “physician”; and
Whereas, The FAA has interpreted this broadly as any professional licensed in a state that is allowed to use the title of “physician”; and
Whereas, In approximately 18 states, chiropractors and other limited license providers have or are seeking authority to perform BasicMed examinations; and
Whereas, The FAA has noted, in its discussion of the BasicMed program, that it does not expect that physicians other than MD or DO would be capable of adequately performing these examinations; and
Whereas, The Department of Transportation has, in the past, issued similar authority non-prescribing physicians, to that of the FAA, as it pertains to the medical examinations to obtain a Commercial Drivers License; therefore be it
RESOLVED, That our American Medical Association advocate for the Federal Aviation Administration to restrict BasicMed examinations for pilots to physicians with prescriptive authority (Directive to Take Action); and be it further
RESOLVED, That AMA Policy H-160.949, “Practicing Medicine by Non-Physicians,” be amended by addition to read as follows:

Practicing Medicine by Non-Physicians H-160.949
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and (6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education; and (7) opposes efforts by federal agencies (i.e., the Federal Aviation Administration and the Department of Transportation) to permit non-prescribing physicians to conduct medical examinations required to obtain special transportation licenses. (Modify Current HOD Policy)

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

Received: 06/06/18
WHEREAS, The Department of Homeland Security has announced a “zero tolerance” policy that requires that all unlawful border crossers be referred to the Department of Justice for prosecution as a misdemeanor of illegal entry, including parents seeking asylum from persecution who enter the U.S. with their children; and

WHEREAS, These children will be treated as if they were “unaccompanied minors,” separated from their parents and sent into facilities administered by the federal government; and

WHEREAS, A policy of universally separating children from their parents entering U.S. borders will do great harm to children, their parents, and their families; and

WHEREAS, Childhood trauma and adverse childhood experiences create negative health impacts that will last an individual’s entire lifespan; and

WHEREAS, Families seeking refuge in the U.S. already endure emotional and physical stress, and separating family members from each other only serves to dramatically exacerbate that stress; therefore be it

RESOLVED, That our American Medical Association urge the Department of Homeland Security, Attorney General Sessions, and President Trump to withdraw its new policy to require separation of children from their parents, and instead, give priority to supporting families and protecting the health and well-being of the children within those families. (Directive to Take Action)

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

Received: 06/07/18
REVISED RESOLUTIONS AND REPORTS

- Res. 222 - Evidence Based Treatment in Substance Abuse Treatment Facilities (notice given in the Handbook Addendum)

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- 106 - Prohibit Retrospective ER Coverage Denial (New York, Texas)
- 110 - Return to Prudent Layperson Standard for Emergency Services (Missouri, Texas)
- 201 - Removing Barriers to Obesity Treatment (Obesity Medicine Association, Colorado, Minority Affairs Section, American Association of Clinical Endocrinologists, American Society for Metabolic and Bariatric Surgery, American Gastroenterological Association, American College of Surgeons, The Endocrine Society)
- 219 - Improving Medicare Patients’ Access to Kidney Transplantation (American Society of Transplant Surgeons, American College of Surgeons)
- 225 - Pharmacy Benefit Managers Impact on Patients (American Society of Clinical Oncology, American College of Rheumatology, American Academy of Neurology)

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

(1) LATE RESOLUTION(S)

The Committee on Rules and Credentials met Saturday, June 9, to discuss Late Resolution(s) 1001 – 1004. Sponsors of the late resolutions met with the committee to consider late resolutions, and were given the opportunity to present for the committee’s consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

• Late 1002 – 340B Program
• Late 1003 – Federal Aviation Administration BasicMed Exams to be Done by Physicians with Prescriptive Authority
• Late 1004 – Separation of Children from their Parents at Border

Recommended not be accepted:

• Late 1001 – Financial Protections for Doctors in Training

(2) REAFFIRMATION RESOLUTIONS

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

• Resolution 101 Medicaid Reform
• Resolution 106 Prohibit Retrospective ER Coverage Denial
• Resolution 107 Opposition to Medicaid Work Requirement
• Resolution 110 Return to Prudent Layperson Standard for Emergency Services
• Resolution 112 Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs
• Resolution 113 Survivorship Care Plans
• Resolution 116 Ban on Medicare Advantage “No Cause” Network Terminations
• Resolution 201 Barriers to Obesity Treatment
• Resolution 202 Universal and Standardized Protocols for Electronic Health Records Data Transition
• Resolution 204 Opposition to Mandated Proficiency in EHR for Licensure
• Resolution 206 Appropriate Use of Telehealth Services
1. Resolution 207 Quality Improvement Requirements
2. Resolution 208 Prior Authorization Requirements for Post-Operative Opioids
3. Resolution 210 Banning the Sale of Bump Stocks
4. Resolution 213 Utilization Review
5. Resolution 214 Strengthening the Background Check System for Firearm Sales
6. Resolution 220 Strengthening the Background Check System for Firearm Sales
7. Resolution 228 Medicare Quality Incentives
8. Resolution 232 Recording Law Reform
9. Resolution 234 Support for Primary Care Enhancement Act
10. Resolution 237 Safe and Efficient E-Prescribing
11. Resolution 242 PBMs and Compounded Medications
12. Resolution 304 – Persons with Intellectual and Developmental Disabilities Designated as a Medical Underserved Population
13. Resolution 306 – Sex and Gender Based Medicine
14. Resolution 404 - Emphasizing the Human Papillomavirus Vaccines as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic
15. Resolution 406 – Support for Public Health Violence Prevention Programs
16. Resolution 415 – Reducing Gun Violence in America
17. Resolution 417 - Reducing Disparities in Obstetric Outcomes, Maternal Morbidity, and Prenatal Care
18. Resolution 422 - School Drinking Water Quality Testing, Monitoring, and Maintenance
19. Resolution 501 – Synthetic Cannabinoids
20. Resolution 510 – Alcohol Use and Cancer
21. Resolution 512 – Physician and Patient Education About the Risk of Synthetic Cannabinoid Use
22. Resolution 518 – Portable Listening Devices and Noise Induced Hearing Loss
23. Resolution 519 – Warning Labels for Childrens Digital and Video Games
24. Resolution 520 – Handling of Hazardous Drugs
25. Resolution 703 – Economic Credentialing
26. Resolution 704 – Non-Payment and Audit Takebacks by CMS
27. Resolution 707 – Health Plan Payment of Patient Cost-Sharing
28. Resolution 708 – Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission
29. Resolution 709 – Prior Authorization for Durable Medical Equipment
30. Resolution 711 – Compensation for Pre-Authorization Requests
31. Resolution 712 – Alternative Payment Models and Vulnerable Populations
Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Jerome C. Cohen, MD, Sharon Douglas, MD, Jan Kief, MD, H. Timberlake Pearce, Jr., MD, William Ritchie, MD, and Cyndi J. Yag-Howard, MD, and on behalf of the committee those who appeared before the committee.

<table>
<thead>
<tr>
<th>Name</th>
<th>Delegate</th>
<th>State/Membership</th>
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<tbody>
<tr>
<td>Jerome C. Cohen, MD</td>
<td></td>
<td>New York</td>
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<tr>
<td>William Ritchie, MD</td>
<td>Alternate Delegate</td>
<td>New Mexico</td>
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<tr>
<td>Sharon Douglas, MD*</td>
<td></td>
<td>Mississippi</td>
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<tr>
<td>Cyndi J. Yag-Howard, MD</td>
<td></td>
<td>American Academy of Dermatology</td>
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<td>Jan Kief, MD</td>
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<td>Colorado</td>
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<tr>
<td>John Montgomery, MD, Chair</td>
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<td>Florida</td>
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<td>H. Timberlake Pearce, Jr., MD</td>
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<td>South Carolina</td>
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* Alternate Delegate
APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

- Resolution 101 Medicaid Reform
  - Medical Care for Patients with Low Incomes H-165.855
  - Giving States New Options to Improve Coverage for the Poor D-165.966
  - Health Savings Accounts in the Medicaid Program H-290.972

- Resolution 106 Prohibit Retrospective ER Coverage Denial
  - Access to Emergency Services H-130.970
  - Out-of-Network Care H-285.904

- Resolution 107 Opposition to Medicaid Work Requirement
  - Opposition to Medicaid Work Requirements H-290.961

- Resolution 110 Return to Prudent Layperson Standard for Emergency Services
  - Access to Emergency Services H-130.970
  - Out-of-Network Care H-285.904

- Resolution 112 Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs
  - Three Day Stay Rule H-280.947

- Resolution 113 Survivorship Care Plans
  - Survivorship Care Plans H-55.969
  - Use of CPT Editorial Panel Process H-70.919

- Resolution 116 Ban on Medicare Advantage "No Cause" Network Terminations
  - Managed Care Contract Deadline D-285.988
  - Network Adequacy H-285.908
  - Qualifications and Credentialing of Physicians Involved in Managed Care H-285.991

- Resolution 201 Barriers to Obesity Treatment
  - Recognition of Obesity as a Disease H-440.842
  - Addressing Obesity D-440.954
  - Obesity as a Major Health Concern H-440.902
  - Recognizing and Taking Action in Response to the Obesity Crisis D-440.980

- Resolution 202 Universal and Standardized Protocols for Electronic Health Records Data Transition
  - Promoting Electronic Data Interchange H-190.978
  - National Health Information Technology D-478.995
  - Principles for Hospital Sponsored Electronic Health Records D-478.973
  - Information Technology Standards and Costs D-478.996
  - EHR Interoperability D-478.972
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- Resolution 204 Opposition to Mandated Proficiency in EHR for Licensure
  - Physician Licensure Legislation H-275.955
  - Medical Licensure H-275.978

- Resolution 206 Appropriate Use of Telehealth Services
  - Coverage of and Payment for Telemedicine H-480.946
  - Evolving Impact of Telemedicine H-480.974

- Resolution 207 Quality Improvement Requirements
  - Pay-for-Performance Principles and Guidelines H-450.947

- Resolution 208 Prior Authorization Requirements for Post-Operative Opioids
  - Clinical Practice Guidelines and Clinical Quality Improvement Activities H-320.949
  - Promotion of Better Pain Care D-160.981

- Resolution 210 Banning the Sale of Bump Stocks
  - Restriction of Assault Weapons H-145.993
  - Ban on Handguns and Automatic Repeating Weapons H-145.985
  - Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

- Resolution 213 Utilization Review
  - Utilization Review by Physicians H-320.973
  - Medical Necessity and Utilization Review H-320.942
  - Utilization Review Standards: Local Considerations H-320.988
  - Confidentiality and Utilization Review H-320.986
  - Medical Necessity Determinations H-320.995
  - Postpayment Utilization Review H-335.999
  - Physicians Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
  - Physicians Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995

- Resolution 214 Strengthening the Background Check System for Firearm Sales
  - Waiting Periods for Firearm Purchases H-145.991
  - Waiting Period Before Gun Purchase H-145.992

- Resolution 220 Strengthening the Background Check System for Firearm Sales
  - Restriction of Assault Weapons H-145.993
  - Ban on Handguns and Automatic Repeating Weapons H-145.985

- Resolution 228 Medicare Quality Incentives
  - MIPS and MACRA Exemption H-390.838
  - Preserving Patient Access to Small Practices Under MACRA D-390.949
APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

- Resolution 232 Recording Law Reform
  - Patient Privacy and Confidentiality H-315.983
  - Patient/Physician Relationship and Medical Licensing Boards H-275.937
  - Protecting the Patient-Physician Relationship H-165.837
  - Confidentiality H-320.994

- Resolution 234 Support for Primary Care Enhancement Act
  - Direct Primary Care H-385.912
  - The Role of Cash Payments in All Physician Practices H-380.984

- Resolution 237 Safe and Efficient E-Prescribing
  - Electronic Prescribing and Conflicting Federal Guidelines D-120.956
  - Federal Roadblocks to E-Prescribing D-120.958
  - Prescription of Schedule II Medications by Fax and Electronic Data Transmission H-120.957

- Resolution 242 PBMs and Compounded Medications
  - Study of Actions to Control Pharmaceutical Costs H-110.992
  - Pharmaceutical Benefits Management Companies H-125.986

- Resolution 304 – Persons with Intellectual and Developmental Disabilities Designated as a Medical Underserved Population
  - Early Intervention for Individuals with Developmental Delay H-90.969
  - Medical Care of Persons with Developmental Disabilities H-90.968

- Resolution 306 – Sex and Gender Based Medicine
  - Medical Education and Training in Womens Health H-295.890

- Resolution 404 - Emphasizing the Human Papillomavirus Vaccines as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic
  - HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872
  - Human Papillomavirus (HPV) Inclusion in High School Education Curricula D-170.995

- Resolution 406 – Support for Public Health Violence Prevention Programs
  - Violence as a Public Health Issue H-515.979
  - Injury Prevention H-10.982
  - Violence Activities H-515.964
  - Public Health Policy Approach for Preventing Violence in America H-515.971
APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

- Resolution 415 – Reducing Gun Violence in America
  - Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
  - Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
  - Epidemiology of Firearm Injuries D-145.999
  - Gun Violence as a Public Health Crisis D-145.995

- Resolution 417 - Reducing Disparities in Obstetric Outcomes, Maternal Morbidity, and Prenatal Care
  - Infant Mortality D-245.994
  - Disparities in Maternal Mortality D-420.993

- Resolution 422 - School Drinking Water Quality Testing, Monitoring, and Maintenance
  - Safe Drinking Water H-135.928

- Resolution 501 – Synthetic Cannabinoids
  - Addressing Emerging Trends in Illicit Drug Use H-95.940
  - Emerging Drugs of Abuse are a Public Health Threat D-95.970

- Resolution 510 – Alcohol Use and Cancer
  - Setting Domestic and International Public Health Prevention Targets for Per Capita Alcohol Consumption as a Means of Reducing the Burden on Non-Communicable Diseases on Health Status H-30.937
  - Screening and Brief Interventions For Alcohol Problems H-30.942

- Resolution 512 – Physician and Patient Education About the Risk of Synthetic Cannabinoid Use
  - Addressing Emerging Trends in Illicit Drug Use H-95.940
  - Emerging Drugs of Abuse are a Public Health Threat D-95.970

- Resolution 518 – Portable Listening Devices and Noise Induced Hearing Loss
  - Reporting Potential for Hearing Loss Due to Personal Listening Devices H-440.957
  - Noise Induced Hearing Loss In Children And Adolescents H-440.897

- Resolution 519 – Warning Labels for Childrens Digital and Video Games
  - Emotional and Behavioral Effects of Video Game and Internet Overuse H-60.915
  - Harmful Effects of Screen Time in Children H-60.911
  - Mass Media Violence and Film Ratings H-515.974

- Resolution 520 – Handling of Hazardous Drugs
  - USP Compounding Rules H-120.930
  - Opposition to USP 800 D-120.941
  - Access to In-Office Administered Drugs H-330.884
APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

- Resolution 703 – Economic Credentialing
  - Volume Discrimination Against Physicians H-180.963
  - Economic Credentialing H-230.975
  - Economic Credentialing H-230.976

- Resolution 704 – Non-Payment and Audit Takebacks by CMS
  - Fraud and Abuse Within the Medicare System H-175.981
  - Due Process for Physicians H-175.982
  - Kennedy-Kassebaum: Fraud and Abuse H-175.985
  - Medicare "Fraud and Abuse" Update H-175.979
  - Medicare Guidelines for Evaluation and Management Codes H-70.952
  - Expedited Review for Clerical Errors on Medicare Enrollment Applications D-330.905

- Resolution 707 – Health Plan Payment of Patient Cost-Sharing
  - Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans H-165.849
  - Administrative Simplification in the Physician Practice D-190.974

- Resolution 708 – Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission
  - Reduction of Burdensome CMS Signature Compliance Requirements D-330.919
  - 48-Hour Signature Rule D-160.987

- Resolution 709 – Prior Authorization for Durable Medical Equipment
  - Medical Necessity and Utilization Review H-320.942
  - Prescription of Durable Medical Equipment H-330.955
  - Managed Care H-285.998
  - Approaches to Increase Payer Accountability H-320.968
  - Prior Authorization and Utilization Management Reform H-320.939

- Resolution 711 – Compensation for Pre-Authorization Requests
  - Prior Authorization and Utilization Management Reform H-320.939

- Resolution 712 – Alternative Payment Models and Vulnerable Populations
  - MACRA and the Independent Practice of Medicine H-390.837
  - Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908
  - Physician-Focused Alternative Payment Models H-385.913
  - Physician Pay-for-Performance Programs H-140.872
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
- 43* American Podiatric Medical Association Request for Official Observer Status in the House of Delegates: Minimal
- 44* CMS Reimbursement Guidelines for Teaching Physician Supervision:
- 45* Licensing of Electronic Health Records:
- 46* Specialty Society Representation in the House of Delegates - Five-Year Review:

**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)**
- 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
SUMMARY OF FISCAL NOTES (A-18)

CMS Report(s)
  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
  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

HOD Comm on Compensation of the Officers
  01# Report of the HOD Committee on Compensation of the Officers: $52,000

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: Minimal
  011 Women Physician Workforce and Gender Gap in Earnings - Measures to Improve Equality: Estimated cost of $200,000 to create, together with the assistance of professional medical societies, an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act.
  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: Modest
  015 Human Trafficking / Slavery Awareness: Modest
  016# Utilization of "LGBTQ" in Relevant Past and Future AMA Policies: Minimal
  017# Revised Mission Statement of the AMA: Minimal
  018* Discrimination Against Physicians by Patients: Modest
  019* Study of Medical Student, Resident, and Physician Suicide: Modest
  020* Advancing the Goal of Equal Pay for Women in Medicine: Modest
SUMMARY OF FISCAL NOTES (A-18)

Resolution(s)

021* Taking Steps to Advance Gender Equity in Medicine: Modest
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 Retrosp ective ER Coverage Denial: Minimal
107 Opposition to Medicaid Work Requirement: Minimal
108 Expanding AMA's Position on Healthcare Reform Options
   (*Additional cited policy contained in Sunday Tote): 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: Estimated cost of $10,000 to study challenges in billing and coding for cancer survivorship care.
114 Inclusion of Bundled Payments Care Improvement (BPCI) Post-Acute only Model 3 in Advanced BPCI: Minimal
115# Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill: Minimal
116# Ban on Medicare Advantage "No Cause" Network Terminations: Modest
117* Supporting Reclassification of Complex Rehabilitation Technology: Modest
118* Payment for Advance Care Planning: Modest
119* Payment for Palliative Care: Modest
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
Resolution(s)

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 (REVISED): Minimal
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
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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
239  Treating Opioid Use Disorder in Hospitals: Modest
240  Treating Opioid Use Disorder in Treatment Facilities: Estimated cost of $304,000 includes professional fees and staff costs for a PR campaign.
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# Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21: Minimal
245# Opposing NCOIL Attempts to Stop Physician Dispensing: Minimal
246# Support for Patients and Physicians in Direct Primary Care: Modest
247# Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program: Modest
248# Opposition to Firearm Concealed Carry Reciprocity: Minimal
249# Support Any Willing Provider Legislation: Modest
250* Clarification of Guidelines for Online Prescribers: Minimal
251* Scope of Practice Expansion Advocacy and Impacts on Physicians and Medical Students: Modest
252* Repeal of Group Purchasing Organizations and Pharmacy Benefit Managers: Modest
253* Separation of Children from their Parents at Border: Modest
254* Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services: Modest
255  Protecting Medical Trainees from Hazardous Exposure: Minimal
256  For-Profit Medical Schools or Colleges: Modest
257  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.
<table>
<thead>
<tr>
<th>Resolution(s)</th>
<th>Importance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>304 Persons With Intellectual and Developmental Disabilities Designated</td>
<td>Minimal</td>
</tr>
<tr>
<td>305 Standardization of Medical Licensing Time Limits Across States:</td>
<td>Minimal</td>
</tr>
<tr>
<td>306 Sex and Gender Based Medicine:</td>
<td>Modest</td>
</tr>
<tr>
<td>307 Healthcare Finance in the Medical School Curriculum:</td>
<td>Modest</td>
</tr>
<tr>
<td>308 Foreign Trained IMGs Obtaining a U.S. License Without U.S. Residency:</td>
<td>Minimal</td>
</tr>
<tr>
<td>309 Foreign Trained IMGs Competency-Based Specialty Exam Without U.S. Residency</td>
<td>Modest</td>
</tr>
<tr>
<td>310 U.S. Institutions With Restricted Medical Licensure:</td>
<td>Modest</td>
</tr>
<tr>
<td>311 Opioid Education for New Trainees:</td>
<td>Minimal</td>
</tr>
<tr>
<td>312 Suicide Awareness Training:</td>
<td>Minimal</td>
</tr>
<tr>
<td>313 Financial Literacy for Medical Students and Residents:</td>
<td>Minimal</td>
</tr>
<tr>
<td>314 Board Certification Changes Impact Access to Addiction Medicine Specialists</td>
<td>Minimal</td>
</tr>
<tr>
<td>315 Peer-Facilitated Intergroup Dialogue:</td>
<td>Minimal</td>
</tr>
<tr>
<td>316 End &quot;Part 4 Improvement in Medical Practice&quot; Requirement for ABMS MOC:</td>
<td>Minimal</td>
</tr>
<tr>
<td>317 Emerging Technologies (Robotics and AI) in Medical School Education:</td>
<td>Minimal</td>
</tr>
<tr>
<td>318 AMA Convene Stakeholders to Transition USMLE to Pass / Fail Scoring:</td>
<td>Modest</td>
</tr>
<tr>
<td>319 All Payer Graduate Medical Education Funding:</td>
<td>Minimal</td>
</tr>
<tr>
<td>320 Young Physician Involvement in Maintenance of Certification:</td>
<td>Minimal</td>
</tr>
<tr>
<td>401 Danger from Bright Vehicle Headlights:</td>
<td>Modest</td>
</tr>
<tr>
<td>402 Schools as Gun-Free Zones:</td>
<td>Minimal</td>
</tr>
<tr>
<td>403 School Safety and Mental Health:</td>
<td>Modest</td>
</tr>
<tr>
<td>404 Emphasizing the Human Papillomavirus Vaccines as Anti-Cancer Prophylaxis</td>
<td>Minimal</td>
</tr>
<tr>
<td>405 Racial Housing Segregation as a Determinant of Health and Public Access</td>
<td>Moderate</td>
</tr>
<tr>
<td>406 Support for Public Health Violence Prevention Programs:</td>
<td>Minimal</td>
</tr>
<tr>
<td>407 Support for Research of Boxes for Babies' Sleeping Environment:</td>
<td>Minimal</td>
</tr>
<tr>
<td>408 Ending Money Bail to Decrease Burden on Lower Income Communities:</td>
<td>Minimal</td>
</tr>
<tr>
<td>409 Food Advertising Targeted to Black and Latino Youth Contributes to Health</td>
<td>Modest</td>
</tr>
<tr>
<td>410 Opposition to Measures that Criminalize Homelessness:</td>
<td>Modest</td>
</tr>
<tr>
<td>411 Reporting Child Abuse in Military Families:</td>
<td>Minimal</td>
</tr>
<tr>
<td>412 Reducing the Use of Restrictive Housing in Prisoners with Mental Illness:</td>
<td>Minimal</td>
</tr>
<tr>
<td>413 Improving Safety and Health Code Compliance in School Facilities:</td>
<td>Minimal</td>
</tr>
<tr>
<td>414 Sex Education Materials for Students with Limited English Proficiency:</td>
<td>Minimal</td>
</tr>
<tr>
<td>415 Reducing Gun Violence in America:</td>
<td>Modest</td>
</tr>
<tr>
<td>416 Medical Respite Care for Homeless Adults:</td>
<td>Modest</td>
</tr>
<tr>
<td>417 Reducing Disparities in Obstetric Outcomes, Maternal Morbidity, and</td>
<td>Modest</td>
</tr>
<tr>
<td>418 A Guide for Best Health Practices for Seniors Living in Retirement</td>
<td>Modest</td>
</tr>
<tr>
<td>419 Violence Prevention:</td>
<td>Modest</td>
</tr>
<tr>
<td>420 Mandatory Influenza Vaccination Policies for Healthcare Workers:</td>
<td>Minimal</td>
</tr>
<tr>
<td>421 Product Date Labels:</td>
<td>Modest</td>
</tr>
<tr>
<td>422 School Drinking Water Quality Testing, Monitoring, and Maintenance:</td>
<td>Moderate</td>
</tr>
<tr>
<td>423 Grill Brush Warning:</td>
<td>Modest</td>
</tr>
</tbody>
</table>
SUMMARY OF FISCAL NOTES (A-18)

Resolution(s)

424  Rape and Sexual Abuse on College Campuses: Modest
425  Hospital Food Labeling: Minimal
426# Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs: Minimal
427# Support Gun Buyback Programs in Order to Reduce the Number of Circulating Unwanted Firearms: Minimal
428# LGBTQIA+ Inclusive Sex Education Alongside Heterosexual Sex Education: Minimal
429# E-Cigarette Ingredients: Minimal
430# Vector-Borne Diseases: Modest
431# Low Nicotine Cigarette Product Standard: Modest
432# Legal Action to Compel FDA to Regulate E-Cigarettes: Modest
433# Firearm Safety: Minimal
434* Health Care Workplace Ergonomics: Modest
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 (Mifeprex): 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: Modest
516  Waste Incinerator Ban: Modest
517  Impact of Natural Disasters on Pharmaceutical Supply and Public Health: Modest
518# Portable Listening Devices and Noise Induced Hearing Loss: Modest
519# Warning Labels for Children's Digital and Video Games: Minimal
520# Handling of Hazardous Drugs: Modest
521# EPA Glider Truck Standard: Minimal
522# Silence Science: EPA Proposed Data Policy: Minimal
523* Biosimilar Interchangeability Pathway: Minimal
524* Naloxone on Commercial Airlines: Minimal
525* Tramadol Change from DEA Schedule IV to Schedule III: Minimal
526* Direct to Consumer Laboratory Testing: 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
SUMMARY OF FISCAL NOTES (A-18)

Resolution(s)

604  AMA Delegation Entitlements: Minimal
605# Practicing Physician Declining Membership Analysis: Minimal
606# Training Physicians in the Art of Public Forum: Estimated cost of $25K (professional fees) to develop training and materials
607# Discounted / Waived CPT Fees as an AMA Member Benefit and for Membership Promotion: Estimated cost of $14,250 to complete requested study.
608* Divestment from Companies Whose Primary Business is Fossil Fuel: Undeterminable
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
712# Alternative Payment Models and Vulnerable Populations: Modest
713# Private Equity Firms: Modest
714# Laboratory Benefit Managers: Minimal
715* The Obligatory Nature and Enduring Purpose of the Self-Governed Organized Medical Staff: Minimal
716* Hospital Closures and Physician Credentialing: not yet determined
717* Impact of the High Capital Cost of Hospital EHRs on the Medical Staff: Moderate

* contained in Handbook Addendum

Minimal - less than $1,000
Modest - between $1,000 - $5,000
Moderate - between $5,000 - $10,000
ORDER OF BUSINESS
SECOND SESSION

Sunday, June 10, 2018
8:00 AM

1. Report of the Committee on Rules and Credentials - John Montgomery, MD, Chair

2. Presentation, Correction and Adoption of Minutes of 2017 Interim Meeting

3. Announcement of Changes in Reference Committees

4. 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)
43* American Podiatric Medical Association Request for Official Observer Status in the House of Delegates (F)
44* CMS Reimbursement Guidelines for Teaching Physician Supervision (B)
45* Licensing of Electronic Health Records (B)
46* Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)

5. 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)

6. 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)
   04 Expanded Access to Investigational Therapies (Amendments to C&B)
   05 Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician Assisted Suicide" and "Aid in Dying" (Amendments to C&B)
   06 CEJA’s Sunset Review of 2008 House Policies (Amendments to C&B)

7. Opinion(s) of the Council on Ethical and Judicial Affairs - Dennis S. Agliano, MD, Chair
   01 Ethical Physician Conduct in the Media (Info. Report)

8. 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)

9. 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)

10. 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)

11. 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)

12. Report(s) of the HOD Committee on Compensation of the Officers - Brooks F. Bock, MD, Chair
01# Report of the HOD Committee on Compensation of the Officers (F)

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

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

--EXTRACTION OF INFORMATIONAL REPORTS--

15. Unfinished business

16. New Business (Introduction of 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)
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011 Women Physician Workforce and Gender Gap in Earnings - Measures to Improve Equality
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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)
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103 Oppose Medicaid Eligibility Lockout (A)
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105 Use of High Molecular Weight Hyaluronic Acid (A)
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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)
115# Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill
(A)
116# Ban on Medicare Advantage "No Cause" Network Terminations (A)
117* Supporting Reclassification of Complex Rehabilitation Technology (A)
118* Payment for Advance Care Planning (A)
119* Payment for Palliative Care (A)
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208  Prior Authorization Requirements for Post-Operative Opioids (B)
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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)
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234  Support for Primary Care Enhancement Act (B)
235  Hospital Consolidation (B)
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244# Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21 (B)
245# Opposing NCOIL Attempts to Stop Physician Dispensing (B)
246# Support for Patients and Physicians in Direct Primary Care (B)
247# Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program (B)
248# Opposition to Firearm Concealed Carry Reciprocity (B)
249# Support Any Willing Provider Legislation (B)
250* Clarification of Guidelines for Online Prescribers (B)
251* Scope of Practice Expansion Advocacy and Impacts on Physicians and Medical Students (B)
252* Repeal of Group Purchasing Organizations and Pharmacy Benefit Managers (B)
253* Separation of Children from their Parents at Border (B)
254* Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services (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)
311 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)
317# Emerging Technologies (Robotics and AI) in Medical School Education (C)
318# AMA Convene Stakeholders to Transition USMLE to Pass / Fail Scoring (C)
319* All Payer Graduate Medical Education Funding (C)
320* Young Physician Involvement in Maintenance of Certification (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)
426# Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs (D)
427# Support Gun Buyback Programs in Order to Reduce the Number of Circulating Unwanted Firearms (D)
428# LGBTQIA+ Inclusive Sex Education Alongside Heterosexual Sex Education (D)
429# E-Cigarette Ingredients (D)
430# Vector-Borne Diseases (D)
431# Low Nicotine Cigarette Product Standard (D)
432# Legal Action to Compel FDA to Regulate E-Cigarettes (D)
433# Firearm Safety (D)
434* Health Care Workplace Ergonomics (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)
518# Portable Listening Devices and Noise Induced Hearing Loss (E)
519# Warning Labels for Children's Digital and Video Games (E)
520# Handling of Hazardous Drugs (E)
521# EPA Glider Truck Standard (E)
522# Silence Science: EPA Proposed Data Policy (E)
523* Biosimilar Interchangeability Pathway (E)
524* Naloxone on Commercial Airlines (E)
525* Tramadol Change from DEA Schedule IV to Schedule III (E)
526* Direct-to-Consumer Laboratory Testing (E)
601 Creation of LGBTQ Health Specialty Section Council (F)
602 Health Fitness Partnerships (F)
603 Eliminating Food Waste Through Recovery (F)
604 AMA Delegation Entitlements (F)
605# Practicing Physician Declining Membership Analysis (F)
606# Training Physicians in the Art of Public Forum (F)
607# Discounted / Waived CPT Fees as an AMA Member Benefit and for Membership Promotion (F)
608* Divestment from Companies Whose Primary Business is Fossil Fuel (F)
701 Employed Physicians Bill of Rights (G)
702 Basic Practice Professional Standards of Physician Employment (G)
703 Economic Credentialing (G)
704 Non-Payment and Audit Takebacks by CMS (G)
705 Modify the Clinical Laboratory Improvement Amendment of 1988 (G)
706 Ensuring Medicare Coverage for Long Term Care (G)
707 Health Plan Payment of Patient Cost-Sharing (G)
708 Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission (G)
709 Prior Authorization for Durable Medical Equipment (G)
710 Code Status Through the Continuum of Care (G)
711 Compensation for Pre-Authorization Requests (G)
712# Alternative Payment Models and Vulnerable Populations (G)
713# Private Equity Firms (G)
714# Laboratory Benefit Managers (G)
715* The Obligatory Nature and Enduring Purpose of the Self-Governed Organized Medical Staff (G)
716* Hospital Closures and Physician Credentialing (G)
717* Impact of the High Capital Cost of Hospital EHRs on the Medical Staff (G)

17. Information Statement

01 airRx www.airrxmedical.com (Information Statement)

18. Report of the Committee on Rules and Credentials - John Montgomery, MD, Chair

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

Reference Committee on Amendments to Constitution and Bylaws (A-18)
Peter H. Rheinstein, MD, JD, MS, Chair

June 9, 2018
Crystal Ballroom A
Hyatt Regency Chicago

1. BOT Report 02 – New Specialty Organizations Representation in the House of Delegates
2. BOT Report 13 – Mergers of Secular and Religiously Affiliated Health Care Institutions and Their Impact on Patient Care and Access to Services
3. CEJA Report 02 – Mergers of Secular and Religiously Affiliated Health Care Institutions
4. BOT Report 23 – Healthcare as a Human Right
5. BOT Report 24 – Appropriate Placement of Transgender Prisoners
6. BOT Report 25 – Recognition of Physician Orders for Life Sustaining Treatment Forms
7. BOT Report 26 – Revision of Researcher Certification and Institutional Review Board Protocols
8. BOT Report 46 - Specialty Society Representation in the House of Delegates - Five-Year Review
9. Resolution 006 – Living Donor Protection Act of 2017 (HR 1270)
10. Resolution 012 – Costs to Kidney Donors
12. CEJA Report 01 – Competence, Self-Assessment and Self-Awareness
13. CEJA Report 03 – Medical Tourism
14. CEJA Report 04 – Expanded Access to Investigational Therapies
15. CEJA Report 05 – Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician Assisted Suicide" and "Aid in Dying"
16. CEJA Report 06 – CEJA’s Sunset Review of 2008 House Policies
17. Resolution 001 – Discriminatory Policies that Create Inequities in Health Care
18. Resolution 002 – FMLA-Equivalent for LGBT Workers
19. Resolution 003 – Proposing Consent for De-Identified Patient Information
20. Resolution 004 – Patient-Reported Outcomes in Gender Confirmation Surgery
21. Resolution 005 – Decreasing Sex and Gender Disparities in Health Outcomes
22. Resolution 007 – Oppose the Criminalization of Self-Induced Abortion
23. Resolution 008 – Health Care Rights of Pregnant Minors
24. Resolution 009 – Improving and Increasing Clarity and Consistency Among AMA Induced Abortion Policies
25. Resolution 010 – Gender Equity in Compensation and Professional Advancement
26. Resolution 021 – Taking Steps to Advance Gender Equity in Medicine

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During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
27. Resolution 011 – Women Physician Workforce and Gender Gap in Earnings - Measures to Improve Equality
28. Resolution 020 – Advancing the Goal of Equal Pay for Women in Medicine
29. Resolution 013 – Opposing Surgical Sex Assignment of Infants with Differences of Sex Development
30. Resolution 014 – Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms
31. Resolution 015 – Human Trafficking / Slavery Awareness
32. Resolution 016 – Utilization of "LGBTQ" in Relevant Past and Future AMA Policies
33. Resolution 017 – Revised Mission Statement of the AMA
34. Resolution 018 – Discrimination Against Physicians by Patients
35. Resolution 019 – Study of Medical Student, Resident and Physician Suicide

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ORDER OF BUSINESS

Reference Committee A (A-18)
Jonathan D. Leffert, MD, Chair

June 10, 2018
Regency Ballroom A
Hyatt Regency Chicago
Chicago

1. Board of Trustees Report 40 - Medicare Coverage of Services Provided by Proctored Medical Students
3. Council on Medical Service Report 2 - Improving Affordability in the Health Insurance Exchanges
4. Council on Medical Service Report 3 - Ensuring Marketplace Competition and Health Plan Choice
5. Resolution 108 - Expanding AMA’s Position on Healthcare Reform Options
6. Council on Medical Service Report 7 - Insulin Affordability
8. Resolution 101 - Medicaid Reform
9. Resolution 103 - Oppose Medicaid Eligibility Lockout
10. Resolution 107 - Opposition to Medicaid Work Requirement
11. Resolution 109 - Medicaid Coverage of Fitness Facility Memberships
12. Resolution 111 - Medicare Coverage for Dental Services
13. Resolution 105 - Use of High Molecular Weight Hyaluronic Acid
14. Resolution 104 - Emergency Out of Network Services
15. Resolution 106 - Prohibit Retrospective ER Coverage Denial
   Resolution 110 - Return to Prudent Layperson Standard for Emergency Services
16. Resolution 116 - Ban on Medicare Advantage "No Cause" Network Terminations

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17. Resolution 102 - Effectiveness of Risk Assessment Models in Representing Healthcare Resources Expended for Infants and Children

18. **Resolution 112 - Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs**

19. Resolution 114 - Inclusion of Bundled Payments Care Improvement (BPCI) Post-Acute only Model 3 in Advanced BPCI

20. Resolution 117 - Supporting Reclassification of Complex Rehabilitation Technology

21. **Resolution 113 - Survivorship Care Plans**

22. Resolution 115 - Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill

23. Resolution 118 - Payment for Advance Care Planning

24. Resolution 119 - Payment for Palliative Care

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ORDER OF BUSINESS
Reference Committee B (A-18)
R. Dale Blasier, MD, Chair

June 10, 2018
Regency Ballroom B

2. Board of Trustees Report 12 – Advocacy for Seamless Interface between Physician Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) (Resolution 212-A-17)
   Resolution 237 – Safe and Efficient E-Prescribing
3. Board of Trustees Report 14 – Integration of Drug Price Information into Electronic Medical Records/
   Barriers to Price Transparency/Bidirectional Communication for EHR Software and Pharmacies/Health Plan, Pharmacy, Electronic Health Records Integration (Resolution 219-A-17; Resolution 213-I-17; Resolution 203-I-17; Resolution 205-I-17)
4. Board of Trustees Report 15 – Advanced Practice Registered Nurse Compact
6. Board of Trustees Report 17 – Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care
7. Board of Trustees Report 18 – Medical Liability Coverage Through the Federal Tort Claims Act (Resolution 214-A-17)
8. Board of Trustees Report 19 – Health Information Technology Principles (Resolution 218-I-17)
9. Board of Trustees Report 41 – Augmented Intelligence (AI) in Health Care Resolution 205 - Augmented Intelligence
12. Resolution 201 – Barriers to Obesity Treatment
14. Resolution 203 – Updating Federal Food Policy to Improve Nutrition and Health
15. Resolution 204 – Opposition to Mandated Proficiency in EHR for Licensure
16. Resolution 206 – Appropriate Use of Telehealth Services
17. Resolution 207 – Quality Improvement Requirements
18. Resolution 208 – Prior Authorization Requirements for Post-Operative Opioids
19. Resolution 209 – Substance Use Disorders During Pregnancy
20. Resolution 222 – Evidence Based Treatment in Substance Abuse Treatment Facilities
   Resolution 240 – Treating Opioid Use Disorder in Treatment Facilities
21. Resolution 223 – Treating Opioid Use Disorder in Hospitals
   Resolution 239 – Treating Opioid Use Disorder in Hospitals
22. Resolution 245 – Opposing NCOIL Attempts to Stop Physician Dispensing
23. Resolution 211 – Clarification from US Department of Justice Regarding Federal Enforcement of Medical Marijuana Laws
24. Resolution 212 – Value-Based Payment System
25. Resolution 228 – Medicare Quality Incentives
26. Resolution 236 – Reducing MIPS Reporting Burden
27. Resolution 247 – Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program
28. Resolution 213 – Utilization Review
29. Resolution 215 – Regulation of Hospital Advertising
30. Resolution 216 – FDA Conflict of Interest
31. Resolution 217 – Reforming the Orphan Drug Act
32. Resolution 227 – An Optional National Prescription Drug Formulary
33. Resolution 238 – Reform of Pharmaceutical Pricing: Negotiated Payment Schedules
34. Resolution 218 – Considering Feminine Hygiene Products as Medical Necessities
35. Resolution 221 – Maintaining Validity and Comprehensiveness of U.S. Census Data
36. Resolution 224 – Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions
37. Resolution 225 – Pharmacy Benefit Managers Impact on Patients
38. Resolution 242 – Pharmacy Benefit Managers and Compounded Medications
39. Resolution 226 – Model State Legislation for Routine Preventative Prostate Cancer Screening for Men Ages 55-69
40. Resolution 229 – Green Card Backlog for Immigrant Doctors on H-1B Visa
41. Resolution 230 – Opposition to Funding Cuts for Programs that Impact the Health of Populations
42. Resolution 231 – Online Controlled Drugs
43. Resolution 232 – Recording Law Reform
44. Resolution 233 – Support for Reauthorization of the Supplemental Nutrition Assistance Program
45. Resolution 234 – Support for the Primary Care Enhancement Act
46. Resolution 246 – Support for Patients and Physicians in Direct Primary Care
47. Resolution 235 – Hospital Consolidation
48. Resolution 241 – Accuracy and Accountability of Physician Compensation Reporting by Drug and Device Companies
49. Resolution 243 – Report Health Care Provider Sex Crimes to Law Enforcement
50. Resolution 249 – Support Any Willing Provider Legislation
51. Resolution 251 – Scope of Practice Expansion Advocacy and Impacts on Physicians and Medical Students
52. Resolution 252 – Repeal of Group Purchasing Organizations and Pharmacy Benefit Managers
53. Resolution 253 – Separation of Children from their Parents at Border
54. Resolution 254 – Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services
55. Late Resolution 1002 – 340B Drug Discount Program
56. Late Resolution 1003 – Federal Aviation Administration BasicMed Exams to be Done by Physicians with Prescriptive Authority
57. Resolution 219 – Improving Medicare Patients’ Access to Kidney Transplantation
58. Resolution 210 – Banning the Sale of Bump Stocks
   Resolution 214 – Strengthening the Background Check System for Firearm Sales
   Resolution 220 – Ban on Semi-Automatic Assault Weapons and High Capacity Ammunition Magazines
   Resolution 244 – Increasing the Legal Age of Purchasing Ammunition and Firearms From 18 to 21
   Resolution 248 – Opposition to Firearm Concealed Carry Reciprocity

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During the reference committee hearing, supplemental materials may be sent to ReferenceCommitteeB@gmail.com or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
ORDER OF BUSINESS
Reference Committee C (A-18)
Sherri S. Baker, MD, Chair

June 10, 2018
Regency Ballroom C
Hyatt Regency
Chicago

2. Resolution 302, For-Profit Medical Schools or Colleges
3. Resolution 307, Healthcare Finance in the Medical School Curriculum
4. Resolution 313, Financial Literacy for Medical Students and Residents
5. *Late Resolution 1001, Financial Protections for Doctors in Training*
6. Resolution 317, Emerging Technologies (Robotics and AI) in Medical School Education
7. *Resolution 306, Sex and Gender Based Medicine*
8. Resolution 312, Suicide Awareness Training
9. Resolution 311, Opioid Education for New Trainees
10. Resolution 301, Protecting Medical Trainees from Hazardous Exposure
12. Council on Medical Education Report 3, Expanding UME Without Concurrent GME Expansion
13. Resolution 319, All Payer Graduate Medical Education Funding
15. Resolution 315, Peer-Facilitated Intergroup Dialogue
16. Resolution 303, Fellowship Start Date
17. Resolution 318, AMA Convene Stakeholders to Transition USMLE to Pass/Fail Scoring
18. Council on Medical Education Report 6, Mental Health Disclosures on Physician Licensing Applications

19. Resolution 305, Standardization of Medical Licensing Time Limits Across States

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

21. Resolution 309, Foreign Trained IMGs Competency-Based Specialty Exam Without U.S. Residency

22. Resolution 310, U.S. Institutions With Restricted Medical License

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


25. Resolution 316, End "Part 4 Improvement in Medical Practice" Requirement for ABMS MOC®

26. Resolution 320, Young Physician Involvement in Maintenance of Certification

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

Reference Committee D (A-18)
Shannon Kilgore, MD, Chair

June 10, 2018 Hyatt Regency
Regency D Chicago

2. Board of Trustees Report 28 – Mandatory Public Health Reporting of Law Enforcement-Related Injuries and Deaths
   Resolution 415 – Reducing Gun Violence in America
   Resolution 419 – Violence Prevention
   Resolution 433 – Firearm Safety
4. Resolution 406 – Support for Public Health Violence Prevention Programs
5. Resolution 427 – Support Gun Buyback Programs in Order to Reduce the Number of Circulating Unwanted Firearms
6. Resolution 403 – School Safety and Mental Health
7. Resolution 402 – Schools as Gun-Free Zones
8. Board of Trustees Report 27 – Policy and Economic Support for Early Child Care
9. Resolution 411 – Reporting Child Abuse in Military Families
10. Resolution 424 – Rape and Sexual Assault on College Campuses
13. Resolution 413 – Improving Safety and Health Code Compliance in School Facilities
15. Resolution 414 – Sex Education Materials for Students with Limited English Proficiency
   Resolution 428 – LGBTQIA+ Inclusive Sex Education Alongside Heterosexual Sex Education
16. Resolution 404 – Emphasizing the Human Papillomavirus Vaccine as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic
17. Resolution 420 – Mandatory Influenza Vaccination Policies for Healthcare Workers
18. Resolution 430 – Vector-Borne Diseases

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21. Resolution 432 – Legal Action to Compel FDA to Regulate E-Cigarettes
Resolution 429 – E-Cigarette Ingredients
22. Resolution 421 – Product Date Labels
23. Resolution 409 – Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities
24. Resolution 425 – Hospital Food Labeling
25. Resolution 423 – Grill Brush Warning
27. Resolution 412 – Reducing the Use of Restrictive Housing in Prisoners with Mental Illness
28. Board of Trustees Report 11 – Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States.
29. Resolution 416 – Medical Respite Care for Homeless Adults
30. Resolution 410 – Opposition to Measures that Criminalize Homelessness
32. Resolution 408 – Ending Money Bail to Decrease the Burden on Lower Income Communities
33. Resolution 401 – Danger from Bright Vehicle Headlights
34. Resolution 426 – Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs
35. Resolution 434 - Health Care Workplace Ergonomics

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ORDER OF BUSINESS

Reference Committee E (A-18)
Douglas Martin, MD, Chair

June 10, 2018
Regency Ballroom D

2. Board of Trustees Report 22 – In-Flight Emergencies (Resolution 516-A-17, Resolve 3)
3. Board of Trustees Report 30 – In-Flight Emergencies (Resolution 516-A-17, Resolve 5)
4. Resolution 524 – Naloxone on Commercial Airlines
6. Board of Trustees Report 38 – Timely Referral to Pain Management Specialist (Resolution 714-A-17)
9. Resolution 515 – Information Regarding Animal-Derived Medications
11. Resolution 526 – Direct-to-Consumer (DTC) Laboratory Testing
12. Resolution 505 – Researching Drug Facilitated Sexual Assault Testing
13. Resolution 506 – Non-Therapeutic Gene Therapies
14. Resolution 508 – Reintroduction of Mitochondrial Donation in the United States
15. Resolution 510 – Alcohol Use and Cancer
16. Resolution 513 – Hand Sanitizer Effectiveness
17. Resolution 514 – Effects of Virtual Reality on Human Health
18. Resolution 519 – Warning Labels for Children’s Digital and Video Games
19. Resolution 518 – Portable Listening Devices and Noise Induced Hearing Loss
20. Resolution 516 – Waste Incinerator Ban
23. Resolution 501 – Synthetic Cannabinoids

Resolution 512 – Physician and Patient Education About the Risk of Synthetic Cannabinoid Use

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ORDER OF BUSINESS

Reference Committee F (A-18)
Julia V. Johnson, MD, Chair

June 10, 2018
Hyatt Regency Chicago
Grand Ballroom
Chicago

Financial
1. Board of Trustees Report 1 – Annual Report
2. Board of Trustees Report 4 – AMA 2019 Dues
4. Board of Trustees Report 34 – AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies
5. Resolution 608 – Divestment from Companies Whose Primary Business is Fossil Fuel

Membership
6. Resolution 602 – Health Fitness Partnership
7. Resolution 605 – Practicing Physician Declining Membership Analysis
8. Resolution 607 – Discounted / Waived CPT Fees as an AMA Member Benefit and for Membership Promotion

House of Delegates
10. Resolution 601 – Creation of LGBTQ Health Specialty Section Council
11. Resolution 604 – AMA Delegation Entitlements

Governance
12. Board of Trustees Report 20 – Anti-Harassment Policy
13. Resolution 603 – Eliminating Food Waste Through Recovery
14. Board of Trustees Report 33 – Plan for Continued Progress toward Health Equity

Medical Practice
15. Board of Trustees Report 35 – Model Hospital Medical Staff Bylaws

During the reference committee hearing, supplemental materials may be sent to steve.currier@ama-assn.org or provided directly to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents, and the like. This email address will only accept supplemental material for the duration of the reference committee hearing.
ORDER OF BUSINESS

Reference Committee G (A-18)
Theodore A. Callanos, II, MD, Chair

June 10, 2018
Regency Ballroom A

1. Board of Trustees Report 31 – Physician Burnout and Wellness Challenges, Physician and Physician Assistant Safety Net, Identification and Reduction of Physician Demoralization
2. Resolution 702 – Basic Practice Professional Standards of Physician Employment
3. Council on Medical Service Report 4 – Health Plans’ Medical Advice
5. Council on Medical Service Report 5 – Financing of Long-Term Services and Supports
6. Resolution 706 – Ensuring Medicare Coverage for Long Term Care
7. Board of Trustees Report 37 – Eliminate the Requirement of H&P Update
9. Resolution 707 – Health Plan Payment of Patient Cost-Sharing
10. Resolution 704 – Non-Payment and Audit Takebacks by CMS
11. Resolution 714 – Laboratory Benefit Managers
12. Resolution 701 – Employed Physicians Bill of Rights
13. Resolution 715 – The Obligatory Nature and Enduring Purpose of the Self-Governed Organized Medical Staff

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

During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.
14. **Resolution 703 – Economic Credentialing**

15. Resolution 705 – Modify the Clinical Laboratory Improvement Amendment of 1988

16. Resolution 713 – Private Equity Firms

17. **Resolution 708 – Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission**

18. Resolution 710 – Code Status Through the Continuum of Care

19. **Resolution 712 – Alternative Payment Models and Vulnerable Populations**

20. Resolution 716 – Hospital Closures and Physician Credentialing

21. Resolution 717 – Impact of the High Capital Cost of Hospital EHRs on the Medical Staff

22. **Resolution 709 – Prior Authorization for Durable Medical Equipment**

23. **Resolution 711 – Compensation for Pre-Authorization Requests**

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

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Report of the AMPAC Board of Directors

Presented by: Vidya S. Kora, MD
Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities during this election cycle. In these uncertain times, our mission remains to provide physicians with opportunities to support candidates for election to federal office who have demonstrated their support for organized medicine, including a willingness to work with physicians to strengthen our ability to care for America’s patients. In addition, we continue to help physician advocates through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully work on a campaign or to run for office themselves. We continue to work hand-in-hand with our state medical society PAC partners to carry out our mission.

AMPAC Membership Fundraising

With the 2018 midterm elections well underway, it is necessary that AMPAC’s participation be at an all-time high in order to remain effective this election cycle. AMPAC receipts for the cycle are $1,760,771, and our success this election cycle begins with you, the leaders in our House of Delegates. It is imperative that we have support from members, preferably at the Capitol Club level. Currently, the HOD AMPAC participation stands at 50 percent and there is much work to be done as the House ended 2017 with a record breaking 77 percent participation rate.

When reviewing the 50 percent of HOD members that contribute to AMPAC, 186 or 77 percent participate at the Capitol Club level. Of the HOD members who participate in Capitol Club are 25 Platinum members, 73 Gold members and 88 Silver members. A special thank you to those members who have already contributed to AMPAC in 2018, your early support is important to our success. If you have not made a 2018 contribution to AMPAC yet, I strongly encourage you to stop by the AMPAC booth today to join or renew your membership.

All current 2018 Capitol Club members have been invited to attend an exclusive Capitol Club Luncheon on Tuesday, June 12 with special guest David Axelrod. Mr. Axelrod is a political adviser and analyst and was the Chief Strategist for Barack Obama’s Presidential campaigns. He currently serves as Director of the University of Chicago's non-partisan Institute of Politics and will be discussing the current political landscape and providing an outlook for what lies ahead with the mid-term elections.

AMPAC is promoting its 2018 Sunset in Sedona Sweepstakes and the winner will be announced during the Interim meeting. The lucky winner will receive accommodations for 4 days/3 nights in a creekside cottage at L’Auberge de Sedona in Sedona, Arizona in September 2019. This trip includes a private day trip to the Grand Canyon, a four-course dinner for two at Cress on Oak Creek and a variety of daily on-property guided activities. Current 2018 Platinum, Gold and Silver contributors are automatically entered into the drawing for the sweepstakes.
**Political Action**

The AMPAC Board’s Congressional Review Committee continues to process 2018 primary contributions and is beginning to look ahead to the general election in the fall. Medicine-friendly candidates, lawmakers in positions of leadership or on committees that deal with medicine’s top issues, in addition to those legislators who are otherwise in unique positions to favorably impact key legislation remain our top priorities.

As the November midterm elections draw near, the national political landscape remains very much in flux and a shift in power in one or both chambers of Congress is a distinct possibility. Regardless of the outcome, AMPAC’s robust involvement in key U.S. House and Senate races all over the country will ensure that medicine has a place at the policy-making table.

**Political Education Programs**

On March 2-4, 26 physicians and medical students had registered to take part in AMPAC’s 2018 Candidate Workshop, held at the AMA’s Washington, DC headquarters. Unfortunately, due to a sudden and severe wind storm that struck Washington, DC the day that most participants we’re scheduled to arrive, 10 registrants were unable to attend due to flight cancelations and other weather related issues. The participants who were able to attend were provided a hands-on learning experience featuring political experts from both sides of the aisle providing expert instruction on how to run a winning campaign. Sessions included topics such as: effective fundraising techniques, crisis management, public speaking, grassroots organization and, in general, how to run a disciplined campaign.

Building on the success of this new programmatic model, AMPAC is proud to announce that the dates for the 2018 Campaign School have been set for December 6-9 at the AMA Washington, DC offices. Running an effective campaign can be the difference between winning and losing a race. Coming off the heels of the 2018 election, the AMPAC Campaign School is designed to give participants the skills and strategic approach they will need out on the campaign trail. Our team of political experts will teach them everything they need to know to run a successful campaign.

I am also proud to announce that nominations are now open for the AMPAC Award for Political Participation. Formerly the Belle Chenault Award for Political Participation, the award recognizes an AMA or AMA Alliance member for outstanding accomplishment through volunteer activities in a political campaign or a significant health care related election issue such as a ballot initiative or referendum. Deadline to submit a nomination is January 31, 2019.

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

**Conclusion**

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates who support AMPAC and the work we do. Your continued involvement in political and grassroots activities ensures organized medicine a powerful voice in Washington, DC.
Whereas, Donald C. Barton, MD was born March 23, 1935 and passed away on April 7, 2018; and

Whereas, Dr. Barton was a tireless supporter of the medical community in Kentucky for more than 47 years; and

Whereas, Dr. Barton was a life member of the Kentucky Medical Association; and

Whereas, Dr. Barton served as President of the Kentucky Medical Association (KMA) from 1987-1988, KMA Vice President from 1985-1986, KMA Board Chair from 1983-1984 and Trustee from the 15th District from 1978-1984; and

Whereas, Dr. Barton utilized his knowledge as a family practice physician to serve as a Delegate followed by service as Senior Delegate to the American Medical Association for more than 20 years; and

Whereas, Dr. Barton served as Chair of the Southeastern Delegation to the AMA from 1995-1997; and

Whereas, Dr. Barton served from 1980-1988 as one of only ten physicians from across the United States on the Reagan-Bush National Advisory Committee; and

Whereas, Dr. Barton honorably served his country as a Captain in the United States Air Force from 1966-1968 and was the recipient of the Air Medal and Bronze Star; and

Whereas, Dr. Barton was the recipient of the Doctor of the Year honors in 1991; and

Whereas, Dr. Barton was the recipient of the KMA’s Distinguished Service Award in 1993; and

Whereas, Dr. Barton will be remembered as a strong advocate for patients and the body of medicine having been quoted saying “The number one priority remains the same-you have to be the patient’s advocate and love the patient and you’ll do well. Medicine will continue to survive as the greatest profession there is.”; and

Whereas, Dr. Barton is survived by his wife of 64 years, Joan and their four children: Donna Vance, Becky Myers, Toni Alton and David Barton, numerous grandchildren and great-grandchildren; and

Whereas, Dr. Barton will be deeply missed by his family and colleagues; be it therefore

RESOLVED, That our American Medical Association do hereby honor the contributions of Dr. Barton and his years of service to organized medicine and the countless patients whose lives were touched by his hard work and dedication; and be it further

RESOLVED, That our AMA extend its sympathy to the family of Dr. Barton and present them with a copy of this resolution.
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)
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CEJA Report(s)
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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

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
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
46* Specialty Society Representation in the House of Delegates - Five-Year Review

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
016# Utilization of "LGBTQ" in Relevant Past and Future AMA Policies
017# Revised Mission Statement of the AMA
018* Discrimination Against Physicians by Patients
019* Study of Medical Student, Resident, and Physician Suicide
020* Advancing the Goal of Equal Pay for Women in Medicine
021* Taking Steps to Advance Gender Equity in Medicine

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
REPORT OF THE BOARD OF TRUSTEES

B of T Report 46-A-18

Subject: Specialty Society Representation in the House of Delegates - Five-Year Review

Presented by: Gerald E. Harmon, MD, Chair

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

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2018 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, “Summary of Guidelines for Admission to the House of Delegates for Specialty Societies,” and AMA Bylaw 8.5, “Periodic Review Process.”

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

The following organizations were reviewed for the 2018 Annual Meeting:

- Academy of Physicians in Clinical Research
- Aerospace Medical Association
- American Academy of Dermatology
- American Academy of Facial Plastic and Reconstructive Surgery, Inc.
- American Academy of Family Physicians
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Academy of Psychiatry and the Law
- American Association for Hand Surgery
- American Association of Clinical Urologists, Inc.
- American Clinical Neurophysiology Society
- American College of Medical Quality
- American Society of Addiction Medicine
- American Society of Echocardiography
- American Society of General Surgeons
- American Society of Ophthalmic Plastic and Reconstructive Surgery
- GLMA: Health Professionals Advancing LGBT Equality
- The Endocrine Society
- Spine Intervention Society
The Academy of Physicians in Clinical Research and the American Society of General Surgeons were reviewed at this time because they failed to meet the requirements of the review in 2017.

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


RECOMMENDATION

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


Fiscal Note: Less than $500
**APPENDIX**

*Exhibit A - Summary Membership Information*

<table>
<thead>
<tr>
<th>Organization</th>
<th>AMA Membership of Organization’s Total Eligible Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy of Physicians in Clinical Research</td>
<td>107 of 248 (43%)</td>
</tr>
<tr>
<td>Aerospace Medical Association</td>
<td>165 of 670 (25%)</td>
</tr>
<tr>
<td>American Academy of Dermatology</td>
<td>3,117 of 13,829 (16%)</td>
</tr>
<tr>
<td>American Academy of Facial Plastic and Reconstructive Surgery, Inc.</td>
<td>180 of 826 (22%)</td>
</tr>
<tr>
<td>American Academy of Family Physicians</td>
<td>10,132 or 73,415 (14%)</td>
</tr>
<tr>
<td>American Academy of Hospice and Palliative Medicine</td>
<td>697 of 3,350 (20%)</td>
</tr>
<tr>
<td>American Academy of Neurology</td>
<td>2,934 of 16,925 (17%)</td>
</tr>
<tr>
<td>American Academy of Psychiatry and the Law</td>
<td>393 of 1,253 (31%)</td>
</tr>
<tr>
<td>American Association for Hand Surgery</td>
<td>200 of 775 (26%)</td>
</tr>
<tr>
<td>American Association of Clinical Urologists, Inc.</td>
<td>409 of 1,387 (30%)</td>
</tr>
<tr>
<td>American Clinical Neurophysiology Society</td>
<td>103 of 268 (38%)</td>
</tr>
<tr>
<td>American College of Medical Quality</td>
<td>179 of 422 (42%)</td>
</tr>
<tr>
<td>American Society of Addiction Medicine</td>
<td>821 of 3,914 (21%)</td>
</tr>
<tr>
<td>American Society of Echocardiography</td>
<td>1,115 of 6,785 (16%)</td>
</tr>
<tr>
<td>American Society of General Surgeons</td>
<td>284 of 811 (35%)</td>
</tr>
<tr>
<td>American Society of Ophthalmic Plastic and Reconstructive Surgery</td>
<td>142 of 555 (26%)</td>
</tr>
<tr>
<td>GLMA: Health Professionals Advancing LGBT Equality</td>
<td>106 of 317 (33%)</td>
</tr>
<tr>
<td>The Endocrine Society</td>
<td>1,016 of 6,915 (15%)</td>
</tr>
<tr>
<td>Spine Intervention Society</td>
<td>398 of 1,736 (23%)</td>
</tr>
</tbody>
</table>

*Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)*

Policy G-600.020
1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.

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

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

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

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

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

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

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

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

10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.
8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

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

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

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

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

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

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

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

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

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

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

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

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of
Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.
Whereas, Patients who request accommodation for racial, cultural, gender, sex, religious or other biases present physicians with difficult conflicts involving their professional obligation to provide nondiscriminatory care, their personal integrity, and their ethical obligations to respect patients’ autonomy and medical best interests; and

Whereas, While in some cases, it may be appropriate for a patient to request a different physician—for instance, requests motivated by deeply held cultural or religious beliefs—the rejection of a physician by a patient motivated by bigotry is less deserving of accommodation; and

Whereas, Existing AMA policy does not specifically address discrimination against physicians by patients, but it does offer ethical guidance for physicians to follow in non-life threatening emergencies when they experience disruptive behavior by patients; and

Whereas, However, when a patient motivated by bigotry rejects a physician, there remains little to no guidance for hospitals and physicians regarding ways of effectively balancing patients’ interests, employment rights, and a physician’s duty to treat; and

Whereas, For many physicians, rejection by patients based on bigotry can be distressing and demeaning experiences, which cumulatively contribute to moral distress and burnout; therefore be it

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

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

Received: 06/09/17
RELEVANT AMA POLICY

Code of Medical Ethics Opinion 1.2.2
The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting their dignity and rights.

Disrespectful or derogatory language or conduct on the part of either physicians or patients can undermine trust and compromise the integrity of the patient-physician relationship. It can make members of targeted groups reluctant to seek care, and create an environment that strains relationships among patients, physicians, and the health care team.

Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:

(a) Recognize that derogatory or disrespectful language or conduct can cause psychological harm to those they target.

(b) Always treat their patients with compassion and respect.

(c) Terminate the patient-physician relationship with a patient who uses derogatory language or acts in a prejudicial manner only if the patient will not modify the conduct. In such cases, the physician should arrange to transfer the patient's care.

AMA Principles of Medical Ethics: I, II, VI, IX

D-373.998 Guidelines for Handling Derogatory Conduct in the Patient-Physician Relationship
Our AMA will work with appropriate organizations to encourage hospitals, health care systems, and organizations to adopt uniform guidelines for physicians to follow in non-life threatening emergencies when they encounter patients who verbally abuse practitioners because of the physician's [or "the practitioner's"] race, ethnicity, or other personal characteristic. Central issues to be addressed would include the importance of recognizing the patient's right to choose his or her physician, the importance of ensuring that each patient has an identified physician responsible for the patient's care, appropriate institutional mechanisms to address abusive behavior by patients (e.g., through patient services or social services), appropriate psychiatric referral or consultation as part of the treatment plan if the derogatory conduct is a consequence of a mental disorder, and an appropriate mechanism to ensure continuity of care for a patient who persistently declines care from the responsible practitioner/attending physician. (BOT Rep. 1, A-09)
Whereas, The American Medical Association addressed the core issue of suicide by physicians and physicians-in-training in 2010; and

Whereas, At that time, several studies had already been carried out with the assistance of records on physician deaths maintained by the AMA; and

Whereas, As a result of these studies, the AMA adopted an extensive body of policy aimed in part at improving physician and medical student access to mental health care, helping to reduce stigma associated with mental health illness that could unfairly impact a physician’s ability to obtain a medical license and impede physicians and medical students from receiving care; and

Whereas, But over the last few years, growing evidence that physicians and physicians-in-training are continuing to face increased burnout, depression and suicide have stirred national discussion; and

Whereas, An updated study on the incidence of and risk factors for suicide by medical students, residents, and physicians is necessary to help the AMA better understand how suicide risk evolves for doctors—from before they enter medical school all the way beyond retirement; therefore be it

RESOLVED, That our American Medical Association conduct a study to accurately quantify the actual incidence of medical student, resident, and physician suicide, and report back with recommendations for action. (Directive to Take Action)

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

Received: 06/09/18
Whereas, Recent studies have demonstrated that there are persistent pay disparities for women physicians that begin early in their careers and across practice settings\(^1,2\), specialties and positions\(^3,4\) --with the gaps more pronounced for mid- and late-career women; and

Whereas, Gender pay disparities exist even when other factors are accounted for, including differences in specialty, age, faculty rank, and metrics of clinical and research productivity\(^1\) and

Whereas, Gaps in compensation between men and women physicians widen over the physician’s career trajectory, particularly for women with intersectionality (those who also identify with other underrepresented groups)\(^5\) and

Whereas, The 2018 Medscape Physician Compensation Report\(^6\) found that male primary care physicians earned almost 18% more than their female counterparts, and among specialists, that gap widened to about 36%; and

Whereas, The American College of Physicians (ACP) recently published a position paper\(^7\) titled “Achieving Gender Equity in Physician Compensation and Career Advancement,” clarifying the organization’s positions and recommendations regarding equal pay in medicine; and

Whereas, The Association of Women Surgeons (AWS) recently published a position paper\(^2\) titled “Strategies for Identifying and Closing the Gender Salary Gap in Surgery;” and

Whereas, Forty-eight states in the United States have some form of equal pay legislation (excluding Alabama and Mississippi)\(^8\) and

\(^1\) Jena AB, Olenski AR, Blumenthal DM. Sex Differences in Physician Salary in US Public Medical Schools. JAMA Intern Med. 2016 Sep 1;176(9):1294-304.
Whereas, The scope of state equal pay laws varies considerably, leading the American Association of University Women (AAUW) to rate states with equal pay protections as either poor, moderate, or strong; and

Whereas, Only nine states were identified by AAUW as having strong equal pay protections and even fewer states have equal pay laws that offer protections, defenses, remedies, preemptive action, and comparable worth provisions; and

Whereas, The Paycheck Fairness Act of 2017 seeks to “(1) restrict the use of the bona fide factor defense to wage discrimination claims, (2) enhance non-retaliation prohibitions, (3) make it unlawful to require an employee to sign a contract or waiver prohibiting the employee from disclosing information about the employee’s wages, and (4) increase civil penalties for violations of equal pay provisions;” and

Whereas, Salesforce, an American cloud computing company, recently undertook regular assessments and adjusted salaries accordingly in order to close pay gaps among employees based on gender and ethnicity, with companies like Adobe, Apple, Facebook, Intel, and Starbucks following suit; and

Whereas, Our AMA has strong existing policy on equal pay in medicine, including (1) further “study [of] gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics,” (2) “develop[ment of] programs to address disparities where they exist,” (3) “urg[ing] 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,” and (4) “collect[ing] and publiciz[ing] information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession;” and

Whereas, Our AMA is well-situated to develop and advance specific legislative proposals; therefore be it

RESOLVED, That our American Medical Association draft and disseminate a report clarifying principles of equal pay in medicine that can form the basis for state and specialty society policy-making, as well as for academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting. (Directive to Take Action)

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

Received: 06/09/18

RELEVANTAMA POLICY
Equal Opportunity H-65.968
Gender Disparities in Physician Income and Advancement D-200.981
Strategies for Enhancing Diversity in the Physician Workforce H-200.951

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(A-18)

Introduced by: Young Physicians Section

Subject: Taking Steps to Advance Gender Equity in Medicine

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

Whereas, Workforce diversity is defined as the presence of people from many different backgrounds, and workforce inclusion represents how these individuals are able to equitably be promoted, compensated, and supported in their careers;¹ and

Whereas, Women physicians have documented gaps in compensation and career advancement at all levels, and these gaps widen over their career trajectory;² and

Whereas, The published literature has documented that progress for women physicians has been slower than would be anticipated given the growing numbers of women in medicine;³ and

Whereas, Traditional justifications for the lack of or slow progress for women in medicine have been refuted⁴ and there has been a shift away from focusing on the women themselves and towards addressing institutional and structural bias and other barriers;⁵ and

Whereas, Medical societies have unique opportunities to support underrepresented physician members with career enhancing opportunities;¹,⁶ and

Whereas, Women physicians have been underrepresented for medical society affiliated career enhancing opportunities including, but not limited to, journal editorial boards,⁷ conference speakers,⁸ and recognition awards;¹ and

Whereas, Reports in the published literature have documented gaps in medical societies’ efforts to tackle workforce and patient health disparities and have called on them to more critically assess their efforts through metrics, outcomes and reporting methodology that is consistent with that used in evidence-based medicine; and

Whereas, Physicians are working together in a grass roots effort to encourage their organizations to be better allies (e.g., the Twitter campaign #SocietiesAsAllies); and

Whereas, The National Institutes of Health (NIH) has speaker guidelines that focus on the inclusion of women in medicine at scientific conferences and publishes workforce inclusion metrics for women in medicine such as grant funding, this has not been the practice of medical societies; and

Whereas, The Association of Academic Physiatrists (AAP) is the first medical society to report in a medical journal its gender inclusion metrics and provide a plan to achieve equitable inclusion in the future; and

Whereas, The National Academies of Science, Engineering, and Medicine (NASEM) published a report in 2004, “Achieving XXcellence in Science: Role of Professional Societies in Advancing Women in Science,” based on the AXXS 2002 Workshop on the same issues; and

Whereas, The American College of Physicians (ACP) recently published a position paper titled “Achieving Gender Equity in Physician Compensation and Career Advancement,” clarifying the organization’s positions and recommendations regarding gender equity in medicine; and

Whereas, The AMA Women Physicians Section supports a number of important initiatives, including Women in Medicine Month, the Women in Medicine Symposium, and the Joan F. Giambalvo Fund for the Advancement of Women; and

Whereas, Our AMA policy H-525.992 supports “the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;” and

10 #SocietiesAsAllies - Twitter Search. 2018; Available at https://twitter.com/search?q=%23SocietiesAsAllies&src=typd.
Whereas, Our AMA policy D-200.981 notes that the organization “will collect and publicize information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession;” therefore, be it

RESOLVED, That our American Medical Association draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, to be submitted to the House for consideration at the 2019 Annual Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings. (Directive to Take Action)

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

Received: 06/09/18

RELEVANT AMA POLICY

Equal Opportunity H-65.968
Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Women in Medicine H-525.992
Our AMA reaffirms its policy of commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine.

Women in Organized Medicine H-525.998
Our AMA: (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession; (2) supports the concept of increased tax benefits for working parents; (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; (4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs; and (5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site.

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.

**Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

**AMA Code of Medical Ethics 9.5.5 Gender Discrimination in Medicine**

Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians. Collectively, physicians should actively advocate for and develop family-friendly policies that: (a) Promote fairness in the workplace, including providing for: (i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family; (ii) on-site child care services for dependent children; (iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations. (b) Promote fairness in academic medical settings by: (i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure; (ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research; (iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks; (iv) structuring the mentoring process through a fair and visible system. (c) Take steps to mitigate gender bias in research and publication.
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
(*Additional cited policy contained in Sunday Tote)
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
115# Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill
116# Ban on Medicare Advantage "No Cause" Network Terminations
117* Supporting Reclassification of Complex Rehabilitation Technology
118* Payment for Advance Care Planning
119* Payment for Palliative Care

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
Comprehensive Health System Reform H-165.847
1. Comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment, is of the highest priority for our AMA.
2. Our AMA recognizes that as our health care delivery system evolves, direct and meaningful physician input is essential and must be present at every level of debate.
Citation: (Res. 613, A-06; Reaffirmation I-07; Res. 107, A-08)

Opposition to Nationalized Health Care H-165.985
Our AMA reaffirms the following statement of principles as a positive articulation of the Association’s opposition to socialized or nationalized health care:
(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.
(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services.
(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.
(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.
(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.
(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.
(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.
(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.
Whereas, Complex rehabilitation technology (CRT) products are medically necessary devices individually configured to meet a person’s unique needs, such as custom manual and powered wheelchairs, adaptive seating systems, alternative positioning systems, and other mobility devices; and

Whereas, The primary end users of CRT equipment are individuals with significant and disabling chronic conditions that result in long-term disabilities necessitating the use of properly fitted CRT for maximum independence in mobility and activities of daily living and leisure; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) currently classifies CRT under the broad category of durable medical equipment (DME) that was created more than 50 years ago; and

Whereas, The current DME category does not distinguish technological differences between CRT and other DME, which often results in limited or no access to CRT; and

Whereas, Congress and CMS recognized within the Medicare Improvements for Patients and Providers Act of 2008 the benefit of a separate classification for complex rehabilitation power wheelchairs and related accessories for individuals with complex chronic conditions that are substantially disabling or life threatening and who have a high risk of hospitalization or other significant adverse health outcomes; and

Whereas, Creating a separate classification for CRT would allow CMS to create additional requirements beyond those that currently exist for the fitting and prescribing of CRT; and

Whereas, DME typically is furnished for in-home use, but CRT often is required for optimal transition from a skilled nursing facility or other long-term care facility to a home or a community setting, as well as for continued use in daily living activities; and

Whereas, An individual requiring a stay at a long-term care facility under Medicare Part A will not be provided DME under Medicare Part B during the stay, which results in patients not receiving the necessary CRT; and

Whereas, Many long-term care facilities do not provide CRT due to cost or lack of expertise with CRT configuration; and
Whereas, Limited access to CRT puts an individual at risk for reduced independence and greater susceptibility to illness, which may result in extended institutionalization, increased morbidity or even death, increased readmission rates, and increased medical costs; therefore be it

RESOLVED, That our American Medical Association advocate for the Centers for Medicare & Medicaid Services to reclassify complex rehabilitation technology as a separate and distinct payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs. (New HOD Policy)

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

Received: 05/22/18

RELEVANT AMA POLICY

Durable Medical Equipment Requirements H-330.945
Our AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; (2) affirm the concept that members of a physician-led interprofessional health care team be enabled to perform delegated medical duties, including ordering durable medical equipment, that they are capable of performing according to their education, training and licensure and at the discretion of the physician team leader; (3) advocate that the initiators of orders for durable medical equipment should be a physician, or a nurse practitioner or physician assistant supervised by a physician within their care team, consistent with state scope of practice laws; and (4) reaffirm the concept that physicians are ultimately responsible for the medical needs of their patients.
Citation: (Sub. Res. 205, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmation A-04; Reaffirmed: BOT Rep. 14, A-13; Modified in lieu of Res. 802, I-13)

Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs D-330.907
Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.
Citation: (Res. 816, I-15)
Whereas, Advance care planning (ACP) consists of discussions of preferences for end of life care, advance directives (AD), selection of a surrogate decision maker or healthcare proxy in a durable power of attorney (DPOA), and often, physician orders for life sustaining treatment (POLST); and

Whereas, Advance care planning is important in helping patients to have the care that they and their families desire, near and at the end of life; and

Whereas, Advance care planning saves money for the medical system, by decreasing unnecessary treatment, hospitalizations, intensive care unit admissions and procedures; and

Whereas, Advance care planning is important for younger patients because, if they have a life-threatening injury or illness, it is more likely to be unexpected, compared to older patients; and

Whereas, The AMA recognized the need for advance care planning in 1990 and at the 1990 Interim Meeting established policy to “encourage all public and private insurers to be required to pay, at a reasonable payment rate, for advance care planning”; and

Whereas, Medicare pays for advance care planning using E&M Codes 99497 and 99498, at whatever age the physician feels is appropriate and as often as necessary; and

Whereas, Medicare Advantage (Medicare C), Medicaid and commercial insurance often do not pay for advance care planning, or limit it to patients with a terminal illness; therefore be it RESOLVED, That our American Medical Association seek Federal legislation to require Medicare Advantage, Medicaid, and commercial insurance to pay for advance care planning whenever the patient’s physician believes that it is appropriate. (Directive to Take Action)

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

Received: 06/02/18

References:
RELEVANT AMA POLICY

Payment for Patient Counseling Regarding Advance Care Planning H-390.916

Our AMA encourages all public and private health insurers to be required to pay, at a reasonable payment rate, for counseling with patients and/or relatives and guardians regarding advance care planning, including goals of care, as an accepted and integral part of good medical care, particularly as it relates to the discussion of advance directives (e.g., living wills and durable powers of attorney for health care).

Citation: (Res. 1, I-90; Reaffirmed: Sunset Report, I-00; Modified in lieu of Res. 101, A-07; Reaffirmation A-09; Modified: Res. 107, A-15)
Whereas, Palliative care is a philosophy of care aimed at improving the patient and family experience and quality of life, regardless of treatment outcomes; and

Whereas, Palliative care can be combined with life prolonging or potentially curative care; and

Whereas, Palliative care improves quality of life and function for patients with cancer and other diseases, and also improves survival; and

Whereas, Palliative care is important in helping patients to have the care that they and their families desire, near and at the end of life; and

Whereas, Palliative care saves money for the medical system, by decreasing unnecessary treatment, hospitalizations, intensive care unit admissions and procedures; and

Whereas, Medicare does not use the term “palliative”, Medicare Part A pays for palliative care in the hospital and for patients in hospice. Medicare Part B pays for outpatient services which are palliative, but the reimbursement rates are often inadequate to cover the cost of providing care; and

Whereas, Medicare Advantage, Medicaid and commercial payers do not have consistent policies to pay adequately for palliative care; therefore be it

RESOLVED, That our American Medical Association seek Federal legislation to require Medicare, Medicare Advantage, Medicaid, and commercial insurance to pay for palliative care, regardless of site of care, whenever the patient’s physician believes that it is appropriate and the patient, or surrogate decision maker, agrees. (Directive to Take Action)

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

Received: 06/02/18

References:
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
44* CMS Reimbursement Guidelines for Teaching Physician Supervision
45* Licensing of Electronic Health Records

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 (REVISED)
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

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

Resolution(s)

229  Green Card Backlog for Immigrant Doctors on H-1B Visa
230  Opposition to Funding Cuts for Programs that Impact the Health of Populations
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
244#  Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21
245#  Opposing NCOIL Attempts to Stop Physician Dispensing
246#  Support for Patients and Physicians in Direct Primary Care
247#  Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program
248#  Opposition to Firearm Concealed Carry Reciprocity
249#  Support Any Willing Provider Legislation
250*  Clarification of Guidelines for Online Prescribers
251*  Scope of Practice Expansion Advocacy and Impacts on Physicians and Medical Students
252*  Repeal of Group Purchasing Organizations and Pharmacy Benefit Managers
253*  Separation of Children from their Parents at Border
254*  Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 230-A-17, “CMS Reimbursement Guidelines for Teaching Physician Supervision,” for report back at the 2018 Annual Meeting. This resolution was introduced by the Michigan Delegation and asked that: Our American Medical Association (AMA) recommend that the Centers for Medicare & Medicaid Services (CMS) change its policy to allow reimbursement for minor procedures performed by residents as long as the supervising physician is present for the key portions of the minor procedure.

BACKGROUND

For major surgical procedures, a teaching physician must be physically present during the key portions of the service and must be immediately available to provide the service during the entire procedure. During minor procedures, which are defined by CMS as lasting five minutes or less, the teaching physician must be physically present during the entire service in order to be reimbursed for the service by Medicare. Specifically, the Medicare Claim Processing Manual states: “For procedures that take only a few minutes (five minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.”

The definition of the critical or key portions of a procedure is defined as “the part or parts of a service that the teaching physician determines are critical or key portions.” Currently, many specialty societies define the key portions of relevant major procedures.

DISCUSSION

Major and Minor Procedures Defined by Time

The Board of Trustees agrees that it is not logical to treat major and minor procedures differently based solely on the length of the procedure. Minor procedures are defined as procedures that take five minutes or less to complete. A procedure is determined to be major or minor based on time alone, with no consideration for the intensity or difficulty of performing the procedure. Therefore, many major procedures that are high-risk, intense procedures only require the physician to be present for the key portion of the procedure, whereas the physician is required to be present for the entire procedure for many less intense, minor procedures.
For example, in a dermatology practice, a physician may only be required to be present for certain key portions of a nasal soft tissue reconstruction procedure being performed by a resident, which is a major, high-intensity procedure. However, the teaching physician would be required to be present for the entire wart removal procedure performed by residents, which is defined as a minor procedure. Other minor procedures that would require a physician to be present throughout the entire procedure include 11719, trimming of nondystrophic nails, or 11055, pairing or cutting of benign hyperkeratotic lesion (corn or callus). The Board of Trustees agrees that procedures should be treated the same regardless of the length of time the procedure takes.

**Key Portions of Procedures**

The definition of the critical or key portions of a procedure is defined as the part or parts of a service that the teaching physician determines are critical or key portions. Currently, many specialty societies define the key portions of relevant major procedures. Therefore, the determination of which portions of a major procedure a physician must be present for are left up to the specialty society, physician, or facility.

The Board agrees that there are some surgeries that may take fewer than five minutes to perform, but which the surgeon would likely need to be present for the entire procedure. For example, 20610 Arthrocentesis, aspiration and/or injection, major joint or bursa without ultrasound guidance, would take fewer than five minutes; however, the teaching physician may need to be present for the entire procedure. On the other hand, there are many minor surgeries where physicians may only need to be present for portions of the procedure, such as a pediatric hearing examination. Therefore, we believe that physicians themselves should determine which portions of a procedure they should be present for, as opposed to relying on the time the procedure takes to complete. Physicians are capable of determining the key or critical portions of both major and minor procedures.

**Billing and Documentation Rules for Teaching Physicians**

The Board of Trustees notes that there are numerous issues in the current billing and documentation rules for teaching physicians that should be reexamined. Making needed changes to current billing and documentation guidelines for teaching physicians would help reduce physicians’ administrative burden, a key focus of the current administration. For example, the U.S. Department of Health and Human Services recently updated the physician billing rules to allow a teaching physician to use medical student documentation, including history, physical exam, and medical student decision making, provided that the physician personally performs or re-performs the physician exam and verifies the student’s documentation. The AMA supported these changes, and will continue to seek opportunities to work with other stakeholders to address billing and documentation rules for teaching physicians and teaching facilities.

**RECOMMENDATION**

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

Fiscal Note: $1,000.

**REFERENCES**

1 Medicare Claims Processing Manual. Chapter 12, Section 100.1.2.
2 Id.
3 Id.
4 Teaching Physician FAQ.
EXECUTIVE SUMMARY

The House of Delegates referred Resolution 218-A-17, “Licensing of Electronic Health Records,” for report back at the 2018 Annual Meeting. This resolution was introduced by the Illinois Delegation and asked that our American Medical Association (AMA) develop model legislation for licensing electronic health records (EHR) with a focus on ensuring system interoperability. This report provides background on the lack of usability and interoperability of EHRs. Recent modifications in federal policy aim to improve EHR usability and interoperability by establishing new technical standards, testing protocols, and federal oversight for EHRs and their vendors. This report also outlines AMA-initiated efforts to support the regulation of EHRs and to improve EHRs.

Federal health information technology (health IT) policy has influenced the development and design of EHRs. EHR functionality is primarily a result of EHR vendors conforming to the Meaningful Use Program and federal EHR certification requirements. As a result, both EHR usability and interoperability have been negatively impacted. In addition to federal influence on EHR design, a number of major technological barriers have contributed to the lack of EHR interoperability. One major factor is a lack of industry consensus on how medical data should be stored and represented in EHRs. Furthermore, the inability of two or more EHRs to accurately match a patient with their records severely limits interoperability.

Recent administrations and Congress have advanced public policy to address a number of health IT-related issues. The Office of the National Coordinator for Health IT has updated its EHR certification program to: focus on the use and testing of interoperability standards; increase the stringency of EHR usability design requirements; require EHRs to support application programing interfaces; increase health IT oversight and surveillance; and improve vendor transparency and disclosure requirements. Recently enacted legislation aims to: reduce regulatory or administrative burdens on physicians; add new public reporting requirements on vendors; add fines for vendors that block information; establish a national provider directory; commission a report to identify patient matching solutions; and create an agreement for the secure exchange of health information between networks.1 Many of the actions taken by Congress and the Administration are underway and will be implemented over the next several months.

The AMA is engaged with federal and private sector stakeholders in the implementation of regulatory updates. Many of the policy changes promoted by Congress and the Administration will take a number of years before improvements to EHRs will be realized. However, the AMA is involved in short-, mid-, and long-term efforts to support the evolving development of EHRs and maximize the use of EHRs while minimizing physician burden.

The Board of Trustees recommends in this report that our AMA continue leading efforts to advance policies to improve the usability and interoperability of EHRs in lieu of developing model legislation to license EHRs.
REPORT OF THE BOARD OF TRUSTEES

Subject: Licensing of Electronic Health Records (Resolution 218-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 218-A-17, “Licensing of Electronic Health Records,” for report back at the 2018 Annual Meeting. This resolution was introduced by the Illinois Delegation and asked that our American Medical Association (AMA):

Develop model legislation for licensing electronic health records with a focus on ensuring system interoperability.

This report provides background on the lack of usability and interoperability of electronic health records (EHRs). Recent modifications in federal policy aim to improve EHR usability and interoperability by establishing new technical standards, testing protocols, and federal oversight for EHRs and their vendors. This report also outlines AMA-initiated efforts to support regulation and improve EHRs.

BACKGROUND: FEDERAL REQUIREMENTS AND TECHNOLOGICAL BARRIERS TO INTEROPERABILITY

The Health Information Technology for Economic and Clinical Health (HITECH) Act, which established both the Meaningful Use (MU) program and the EHR certification process, has radically increased the adoption of EHRs by health care providers since 2009. The HITECH Act’s monetary incentives are seen as the primary driver of EHR uptake across the nation. In fact, over 85 percent of physicians use an EHR today. However, the hope and promise of EHRs to provide greater efficiency in health care, improve care coordination, and facilitate data exchange have not materialized.

Federal Requirements: EHR Certification Requirements, Meaningful Use, and Advancing Care Information

The EHR certification process, outlined in HITECH, directs the Office of the National Coordinator for Health Information Technology (ONC) to develop health information technology (health IT) certification criteria, a health IT testing framework, and a certification process. This process specifies what EHR vendors must include in their products to become certified EHR technology (CEHRT). ONC’s certification process attempts to ensure that EHRs are interoperable—that is, able to exchange, incorporate, and present information to a physician in a contextual and meaningful manner. However, the act of two computers sending and receiving data, which is what
is predominantly tested during the certification process, does not constitute functional interoperability. Unfortunately, vendors narrowly follow the certification requirements, spending the majority of their time meeting Centers for Medicare & Medicaid Services (CMS) and ONC mandates, while allowing for little time and few resources to address physician and patient needs. Additionally, these certification criteria are only part of a more complex federal process in which EHR vendors participate to sell their products. Other entities, including testing and certifying organizations, play a role in an EHR’s path to the marketplace, but their policies and procedures are still governed by federal requirements.

Meanwhile, physicians must use CEHRT to participate in federal reporting programs such as MU and Advancing Care Information (ACI), a component of CMS’ Quality Payment Program (QPP). Despite the MU program’s intent to enhance patient access to health information and increase the efficiency and quality of care, many of the program’s requirements had the opposite effect. Furthermore, the MU program’s requirements continued to drive the design priorities of many EHR vendors, resulting in electronic systems that promote MU regulatory compliance over clinical need, patient well-being, and general innovation. The lack of interoperability among EHRs is a direct result of this misalignment. This can be attributed to the required use of immature technical standards, the federal government’s lack of semantic and syntactic testing for interoperability, and MU measures that prioritized measurement and reporting over enabling clinically meaningful data exchange. Though physicians who are eligible for the QPP no longer need to participate in the MU program, many of the MU program’s requirements were carried over into ACI—resulting in the continuation of measure-driven design requirements for EHRs.

In sum, while it is widely known that ONC’s certification program is primarily designed to validate an EHR’s ability to meet MU and ACI requirements, it is also clear that the program has become the high watermark for EHR design. Technology and data exchange standards exist widely across other industries where information seamlessly interoperates. However, health IT continues to lack focus on interoperability and usability as a result of federal priorities and vendor capitulation.

**Technological Barriers**

Technical barriers also contribute to the process of achieving interoperability. Data stored within one EHR system may not be compatible with another vendor’s products, especially if such systems are highly customized or a mismatch exists between the source EHR and the receiving system. For example, many first generation EHRs did not consistently code all patient information stored in their systems, leaving data as free text. In this format, the data are not easily transferred, interpreted, or incorporated in the receiving EHR. An additional technical challenge is the lack of consensus on how data should be represented. Data that are able to be codified are not necessarily coded in a consistent manner between EHR vendors. For example, a vendor may choose to describe laboratory test orders and results in terms of Logical Observation Identifiers Names and Codes (LOINC) and Systematized Nomenclature of Medicine—Clinical Terms (SNOMED-CT). However, both health IT vendors and health care facilities utilize some discretion when coding medical information, especially when there is a lack of industry consensus or agreement on the coding or terminology that should be used. While there are ONC certification requirements that specify data structure, currently these requirements only address a subset of the entire patient medical record. Medical records that are then coded to this standard often lack medically relevant information that patients and clinicians need. Furthermore, this discrepancy can negatively affect the interoperability between EHRs. The construction of reliable and reusable clinical code sets is essential when re-using EHR data, yet code set definitions...
are rarely transparent or consistently shared. This lack of methodological standards for the management (construction, sharing, revision, and reuse) of clinical code sets is an additional issue that should be addressed to enable system-to-system interoperability.

The inability of two or more health IT systems to accurately match a patient with their records severely limits interoperability. Patient matching is the ability to link a patient to his or her health records that may be held at multiple locations. Researchers have found match rates as low as 50 percent when matching across health care facilities. Incorrectly linking records to a patient limits the availability of critical data, even within the same EHR or health system. Exchanging information requires a consistent, reliable mechanism for matching patients to their records. In practice, patient matching is the process of comparing different demographic elements from different health IT systems to determine if they refer to the same patient.

From an interoperability perspective, the ability to match patients and their records efficiently, accurately, and at scale is critical. Patient matching is needed to enable the interoperability of health data for all purposes. Additionally, patient matching also requires careful attention to its effect on patient safety and administrative costs. While numerous recommendations have been issued over the years to tackle different aspects of patient matching, it is important to recognize that the entire health care system can impact its performance—from data capture at patient registration to the technology and algorithms along the way. At the same time, there has been little transparency about how well current patient matching algorithms perform.

**RECENT POLICY AND TECHNICAL EFFORTS TO ADVANCE EHR UTILITY**

Both Congress and the recent administrations have made significant advances in policy to address a number of health IT-related issues. Many of the EHR issues addressed in this report originated due to the inability of health IT certification to adapt to changes in technology or physician and patient needs. Health IT certification is a protracted process, often taking between eight and 10 months between proposed and final rules. Health IT developers then need between 18 and 24 months to incorporate federal certification requirements into their products. This cycle can create “new” EHRs that are two and a half years old before they are even available in the market. ONC recognized this and has altered their certification process starting with the 2015 Edition. ONC expects to make smaller, but more frequent certification changes over time.

Congress has also acted to establish much-needed focus and priorities in health IT development, design, testing, and use. The 21st Century Cures Act, discussed in more detail below, articulates Congress’ intent to improve health IT development and certification while also establishing forward-looking goals focused on physician need and patient care. Furthermore, Congress has established feedback mechanisms and agency reporting requirements to bolster oversight.

Many of the actions taken by Congress and recent administrations are underway and will be implemented over the next 12 months. However, given the historically intransigent nature of health IT policy, it is expected to take one to two health IT product development cycles before physicians and patients experience the benefits of recent regulatory changes.

**ONC’s 2015 Edition Health IT Certification**

ONC has taken a number of steps to address EHR usability and interoperability concerns through its 2015 Edition health IT certification criteria. The use of 2015 Edition EHRs will most likely be required for participation in the QPP starting in 2019. While the availability of 2015 Edition EHRs is still less than 10 percent of all EHR products on the market, improvements in EHR usability,
interoperability, vendor practice transparency, and product safety will become more prevalent in
the coming months.\textsuperscript{16}

Updated interoperability standards

In a January 2015 letter to ONC, the AMA, along with 36 other medical societies and
organizations, made a number of recommendations to improve the functionality of certified
EHRs.\textsuperscript{17} One key recommendation was for ONC to improve the Consolidated Clinical Document
Architecture (C-CDA) guidance and testing to further support data exchange. As identified in our
letter, the C-CDA standard allows for vendor optionality in its implementation, yet its use is
mandatory in the MU and ACI programs. The offset of prescriptive regulations on use without the
necessary oversight on the health IT developer has led to deficiencies in interoperability.\textsuperscript{18}
However, 2015 Edition Certification identifies new implementation guides and testing. This,
coupled with an updated C-CDA version, i.e., R2, will help bolster inter-EHR vendor
communication. Furthermore, ONC has increased its testing rigor on standards and system
performance.

Increased stringency on EHR safety enhanced design requirements

In our January 2015 letter, the AMA also cited concerns with ONC’s certification process for
validating whether EHR vendors used proper User Centered Design (UCD) techniques. Experts in
human-factors design note that health IT vendors should meet a minimum level of UCD principles.
Past versions of health IT certification lacked focus on UCD principles. The AMA recommended
ONC increase the robustness of its UCD certification requirements and make testing reports easily
accessible and understandable to the physician consumer. 2015 Edition expands the number of
certification usability criteria. UCD requirements have been expanded with increased attention on
submission requirements and compliance guidance.

Application Programing Interfaces (APIs)

In late 2014, the AMA released a new framework for improving EHR usability.\textsuperscript{19} This framework,
developed with the support of an external advisory committee of noted experts in the field of health
IT, outlined eight usability priorities, including the need for EHR modularity and data liquidity. In
each instance, APIs were identified as an important contributor to facilitating these goals. ONC’s
2015 Edition identifies APIs as one method for providing greater access to patient data in EHRs.
ONC’s intent is to guide the health IT market in this direction. Although APIs are nothing new to
software development, their use in health IT has been slow to gain traction. With advancements in
technical standards, such as Fast Healthcare Interoperability Resources (FHIR), and platforms such
as Substitutable Medical Applications & Reusable Technology (SMART), 2015 Edition API
requirements are poised to improve EHR usability and interoperability.

“In the field” health IT surveillance

Health IT products are complex and must be thoroughly tested and evaluated during development,
deployment, and implementation. Many variables affect the performance of EHRs once they are
installed and used by physicians, including customization, aging hardware, external dependencies,
and an end user’s level of training. This has led to confusion with actual EHR performance. With
2015 Edition, and further expanded by ONC’s Enhanced Oversight and Accountability process, the
agency recognized these concerns.\textsuperscript{20} To increase transparency and ensure physicians have more
clarity around their product’s capabilities, as part of health IT certification, ONC now requires
EHR vendors’ marketing materials or contract requirements to comport with actual EHR functionality and capabilities.

ONC’s health IT surveillance and maintenance process now includes randomized in-the-field surveillance and the ability for the agency to react to end-user reported concerns with certified product performance. ONC prioritized implementation surveillance on health IT capabilities related to interoperability, patient safety, and privacy and security.

**Transparency and disclosure requirements**

In addition to the complexity of health IT products, the actual long-term costs of EHRs have not always been clear. Once a product is installed, an EHR vendor typically requires a monthly maintenance fee based on the initial cost of the product. These fees can range from a few thousand to tens of thousands of dollars per month. Additionally, each custom software change or interface needed to meet MU requirements contributes to unexpected costs, which burden physicians and divert resources from patient care.

In 2013 and 2015, the AMA sponsored two RAND studies which found that the lack of resources, both financial and human, needed to manage the increasing level of administrative challenges are a significant issue facing physicians. As a result of AMA advocacy, EHR vendors are now required to provide greater transparency related to vendor costs and product capabilities. 2015 Edition requires the disclosure of fees to enable or use all EHR functions.

**21st Century Cures Act**

With bipartisan support, Congress passed and President Obama signed into law the 21st Century Cures Act (Cures) in December of 2016. Cures covers a wide array of health care issues, most notably focusing on medical research and the approval process for new medications and medical devices. Cures also contains a number of provisions directly impacting the development of health IT. Cures directs the Secretary of the U.S. Department of Health and Human Services (HHS) to identify methods to: reduce physician documentation burden related to EHRs; increase the transparency of EHR usability, security, and functionality; focus efforts on health IT interoperability; establish penalties for data blocking; establish a digital health care provider directory; and directs the Government Accountability Office (GAO) to conduct a study to review patient matching policies and activities.

Reduce regulatory or administrative burdens

Cures directs HHS to establish a goal, develop a strategy, and make recommendations to reduce regulatory or administrative burdens relating to the use of EHRs. Prior to leaving, Secretary Tom Price, MD, directed ONC to coordinate a cross-agency effort to reduce burden. ONC is in the process of establishing working groups and a series of listening sessions to address EHR usability, electronic quality measurement, documentation burden, and state-based issues. The AMA is actively engaged with ONC and CMS on these initiatives. ONC will release a report to Congress in early 2019.

**Transparency reporting on usability, security, and functionality**

Cures directs HHS to support and convene stakeholders to develop new reporting criteria for health IT developers. Cures further requires HHS to focus this development on priority uses of health IT, including: the implementation of EHR incentives programs (QPP and MU); quality of care, public
health, clinical research, privacy and security, innovation in health IT, patient safety, usability, and individual access. ONC will coordinate this activity. ONC intends to convene stakeholders, review existing standards, and make determinations on future standards and implementation specifications. ONC has signaled their intent to initiate this activity beginning in early 2018.

Interoperability and information blocking

Cures requires, as a condition of health IT certification, developers to meet more stringent interoperability requirements. This includes not engaging in information blocking, which is defined in Cures as preventing, discouraging, or interfering with the access, exchange, or use of information. Furthermore, HHS is directed to initiate rulemaking to identify and define reasonable and necessary activities that do not constitute information blocking. Cures provides HHS’ Office of Inspector General (OIG) the authority to investigate and enforce penalties of up to $1 million per violation for developers who block information. In late 2017, the AMA met with the OIG to discuss information blocking. We provided ideas to inform HHS’ work on further defining what should and should not be considered as information blocking, specifically as it relates to EHR vendors and physicians. ONC has signaled their intent to release a proposed rule on information blocking in spring 2018.

Provider directory

Cures directs HHS to establish a digital health care provider directory within three years of the Act’s enactment. HHS has flexibility in its approach, allowing the agency to utilize an existing provider directory to make digital contact information available. The directory must include information at both the individual health care provider level and health facility or practice level. Congress’ intent is to establish a comprehensive index of providers and their associations with health care facilities or practices.

Patient matching report

Cures directs the GAO to conduct a study, within one year of the Act’s enactment, to review the policies and activities of ONC and other stakeholders to ensure appropriate patient matching. Congress identified patient matching as a major impediment in the exchange of information. However, since 1999, every HHS appropriations bill has prohibited the agency from allocating resources to the adoption a unique patient identifier. This has long been interpreted to be a de facto ban on any work related to matching patients with their records. However, in addition to the Cures policy review, a recent budget bill passed by Congress and signed into law by President Trump enables HHS to be a technical adviser and assist industry groups’ work on patient identification and patient matching. The bill allows ONC and CMS to assist the private sector in developing a “national strategy” to match patients to their health information. Furthermore, the GAO has reached out to the AMA to provide information on the common challenges that physicians face when matching patient records. Our feedback will be included in the GAO’s forthcoming patient matching report.

Trusted Exchange Framework

Cures directs ONC to convene stakeholders to develop or support a framework and agreement for the secure exchange of health information between networks, to provide for testing of a voluntary framework and agreement, and publish a list of networks that adopt the agreement. Congress’ intent is for a national trust and governance framework that ensures health information is available to patients and physicians and supports the management of patient health and care. ONC released a
draft of its framework in January 2018. The draft framework proposes policies, procedures, and
technical standards necessary to advance a single “on-ramp” to interoperability. In February 2018,
the AMA provided comments to ONC on its draft framework proposal.25 A final draft of the
combined Trusted Exchange Framework and Common Agreement (TEFCA) will be released in
late 2018.

DISCUSSION

The AMA is engaged with federal and private sector stakeholders in the implementation of
regulatory updates. As discussed in this report, many of the policy changes promoted by Congress
and the Administration will take a number of years before improvements to health IT will be
realized. However, the AMA is involved in short-, mid-, and long-term efforts to support the
development of EHRs and maximize the use of EHRs while minimizing physician burden.

ONC’s release of their 2015 Edition Health IT Certification final rule signaled the agency’s intent
to address a number of concerns and considerations raised by the AMA and other physician
organizations.26 Pursuant to AMA Policy D-478.973, “Principles for Hospital Sponsored Electronic
Health Records,” the AMA was successful in focusing efforts on increased stringency around EHR
usability and interoperability certification and vendor practice transparency. While much of ONC’s
work is tied to MU and ACI compliance efforts, the AMA has been successful in easing the EHR
burden on physicians. In May 2017, AMA senior leadership met the Trump Administration’s
newly appointed National Coordinator for Health IT. This meeting was a culmination of a multi-
month advocacy effort to delay the federal requirement that physicians must adopt, purchase, and
upgrade new EHRs. Initially, physicians were expected to migrate from 2014 Edition EHRs to
2015 Edition by January 2018. While many enhancements are expected in 2015 Edition EHRs, at
that time few vendors had fully upgraded their systems. Fewer than 70 of the over 3,700 products
available had been certified to 2015 Edition. Importantly, the vast majority of the certified 2015
Edition products were from a small number of vendors. Requiring physicians to upgrade to 2015
Edition technology by 2018 would have limited choice by forcing physicians to select a system
from approximately one percent of existing products. In addition, physicians may have been driven
to switch vendors or utilize a system that was not suitable for their specialty or patient population.27
Pursuant to AMA Policy D-478.996, “Information Technology Standards and Costs,” the AMA
was successful in delaying this requirement until 2019.

Recent conversations with health IT vendors have confirmed that 2015 Edition EHR products
would not have been available by January 2018. This has resulted in two important developments.
First, 2015 Edition products that have already been certified cater primarily to large health systems
and hospitals. While only a handful of health systems have adopted 2015 Edition EHRs, their
experience with these products has provided much needed real-world feedback. Health IT vendors
have since been able to incorporate front-line physician experience into their product design.
Second, the delay in adoption has extended vendors’ development timeline. EHR vendors have
signaled this will enable them to incorporate additional physician requirements and patient care
needs into their products.

The AMA participates in multiple meetings and workgroup sessions, providing front-line physician
experience back to developers. In addition to supporting usability for physicians, the AMA is also
involved in efforts to identify best practices for the implementation of EHRs. Research has shown
that increased support is necessary for the successful integration of technology into complex health
care environments.28 The health IT vendor community is expecting to utilize the delay in adoption
as an opportunity to study the impact of implementation and customization decisions on physician
satisfaction.
Activating a new EHR in a medical practice requires a redesign of clinic workflows. There are many changes that the care team will have to anticipate for a smooth transition to the new electronic record. This involves a multi-disciplinary approach to prepare the new system, ensure privacy and security compliance, design practice workflows, train the care team, and manage the adoption process. Pursuant to AMA Policy D-478.972, “EHR Interoperability,” the AMA has created a STEPS Forward™ module designed to assist the practice in adopting and implementing a new EHR. This, along with all STEPS Forward modules, is eligible as an Improvement Activity (IA) in the QPP and Continuing Medical Education (CME) credit.

While the total impact of Cures legislation on interoperability will take many years before it is felt, HHS is actively engaged in implementing provisions focused on the reduction of physician burden. The AMA strongly agrees that burdensome documentation requirements and the associated onerous features of EHRs degrade communication among health care professionals and detract from patient care.

The AMA is committed in working with CMS and ONC, as well as other stakeholders, to identify strategies to ease these pain points. Pursuant to AMA Policy D-478.995, “National Health Information Technology,” the AMA recently provided the Administration a high-level framework for dealing with documentation burden associated with EHRs. In it, the AMA identified, as a first step, the need to address documentation guidelines. Current documentation guidelines require physicians to include a variety of additional information simply to justify code selection as opposed to prioritizing documentation relevant to the patient’s current and future treatment. Consequently, EHR vendors use very prescriptive methods to capture “structured” information to align physician services with coding levels—adding unnecessary and extraneous work that detracts from the physician/patient narrative. It should be noted, however, that a comprehensive reform of documentation guidelines will require a multi-year, collaborative effort among clinical, federal, payer, and health IT stakeholders.

Furthermore, the AMA’s efforts to improve health IT interoperability and usability go well beyond federal advocacy. While there is a need for new, digital health innovations to improve patient care, it is equally important that innovations are informed by knowledgeable experts who represent a wide-range of clinical specialties. The AMA plays a leading role in the House of Medicine, and is uniquely positioned to bring physicians and innovators together to collaborate on new health care technology and to help ensure proper approaches to interoperability by focusing on the point of care. Through its ongoing work and digital platforms like its Physician Innovation Network, the AMA is providing opportunities for physicians to engage in innovation and share their ideas, expertise, and real-world perspective on the effectiveness of technology in medical practice settings. From revitalizing medical practices to ensuring that digital health is interoperable, usable, and provides high-quality patient care, the AMA is helping physicians navigate and succeed in a continually evolving health care environment.

To support this goal, the AMA established Health2047 in early 2016. Health2047 is a Silicon Valley-based independent, for-profit studio that combines expertise from diverse backgrounds—physicians, engineers, coders, behavioral economists, and psychologists—in development of new solutions. Health2047’s mission is to develop, guide, and commercialize disruptive ideas that enhance—at the system level—the practice of health care. By combining the deep knowledge base of the AMA with seasoned innovators in medicine, technology and science, Health2047 is creating products that make health care delivery more effective and efficient. Health 2047 recently launched a new company, Akiri. Its first product, Akiri Switch, is a subscription-based, secure private network that transmits health data through a standardized system. Akiri will bring the first network-as-a-service platform to the health care industry with the intent of: enabling
interoperability protected by advanced security protocols; realigning health care technical systems
around real-world care needs; improving productivity while reducing physician burden; and
facilitating value-based care models.

Another major activity is the AMA’s Integrated Health Model Initiative (IHMI). The IHMI is a
collaborative effort across health and technology sectors to build a comprehensive data model for
organizing and exchanging information to realize semantic and syntactic interoperability and
improve patient care. IHMI uses the best available science to incorporate essential data elements
around function, state and patient goals to improve patient care. IHMI fills the need for a shared
framework for organizing health data, emphasizing patient-centric information, and refining data
elements to those most predictive of achieving better outcomes. IHMI supports a continuous
learning environment to enable interoperable technology solutions and care models that evolve
with real-world use and feedback while facilitating interoperability. As IHMI launches, the focus is
currently on:

• Hosting clinical and issue-based communities focused on costly and burdensome areas. This
  fosters collaborative efforts around common interests and areas of need, such as hypertension
  management, diabetes prevention, asthma function, and identifying the best available science
  and practices that define patient-centric care.
• Providing a clinical validation process to determine and apply appropriate clinical
  frameworks. Participants will provide contributions and feedback online to specify data
  elements and relationships. Clinical content submissions will go through a validation process
  to review clinical applicability.
• Specifying a model to encode information in the IHMI data model. Clinical content will
  enable configurations of the model and reference value sets that can be distributed.

Participation in IHMI is open to all health care and technology stakeholders, and early
collaborators include IBM, Cerner, Intermountain Healthcare, American Heart Association (AHA),
American Medical Informatics Association (AMIA), as well as a growing list of other individuals
and organizations.

While Resolution 218-A-17 highlights issues with EHR interoperability, recent technical, policy,
and private-sector efforts are currently underway that are expected to allow for significant
improvements in EHR design, testing, certification, and use. Developing model state legislation for
the licensure of EHRs will hinder these efforts and could create state-specific barriers to
interoperability by establishing different standards among states. This is especially true given the
ease and capability of data to cross-state lines. State licensure could also result in EHR vendors
passing additional costs on to the physician. Furthermore, the AMA is already involved in a
number of public/private efforts that are in the initial stages of affecting health IT design, usability,
and interoperability that are aimed at addressing the concerns raised in Resolution 218-A-17.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of
Resolution 218-A-17 and the remainder of the report be filed:

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

Fiscal Note: Less than $500.

REFERENCES

APPENDIX —AMA POLICY

Policy D-478.995, “National Health Information Technology”
(1) Our AMA will closely coordinate with the newly formed Office of the National Health
Information Technology Coordinator all efforts necessary to expedite the implementation of an
interoperable health information technology infrastructure, while minimizing the financial burden
to the physician and maintaining the art of medicine without compromising patient care; (2) Our
AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and
computerized physician order entry (CPOE) user interface design during the ongoing development
of this technology; (B) advocates that medical facilities and health systems work toward
standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for
continued research and physician education on EHR and CPOE user interface design specifically
caring 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;
and (8) Our AMA will advocate for appropriate, effective, and less burdensome documentation
requirements in the use of electronic health records.

Policy D-460.968, “The Precision Medicine Initiative”
(1) Our AMA will work with the Precision Medicine Initiative (PMI) to gather input from
physicians to assist in the planning stages of the initiative and to improve awareness and
willingness to recruit patients as participants; (2) Our AMA encourages the PMI to develop
resources that will assist physicians in understanding the goals of the PMI, how to recruit and
enroll patients, and how to best use the research results generated by it; and (3) Our AMA
continues to advocate for improvements to electronic health record systems that will enable
interoperability and access while not creating additional burdens and usability challenges for
physicians.

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

Policy 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.

Policy D-478.973, “Principles for Hospital Sponsored Electronic Health Records”
(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; and (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.

Policy 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.
Whereas, Telemedicine is a means of providing a medical service, consistent with accepted standards of care and the establishment of a valid patient-physician relationship; and

Whereas, When telemedicine is medically necessary, there should be no state or federal prohibition against physicians with a valid patient-physician relationship diagnosing patients with mental and behavioral health disorders, consistent with accepted standards of care, and prescribing appropriate medications, including controlled substances, for these patients; and

Whereas, The Ryan Haight Act has certain in-person medical evaluation requirements that generally must be satisfied prior to issuing a prescription for a controlled substance through the Internet; and

Whereas, The Ryan Haight Act contains seven exceptions to the per-se in-person medical evaluation requirement for physicians engaged in the “practice of telemedicine,” but those exceptions, as currently drafted and implemented, are highly technical and have limited utility in the diagnosis and treatment of mental and behavioral health disorders; and

Whereas, There have been recent legislative efforts at the federal level to expand the utility of the exceptions for physicians diagnosing and treating mental and behavioral health disorders (e.g., by attempting to impose a deadline on the attorney general with the secretary of the U.S. Department of Health and Human Services to issue interim final rules related to the special registration exception); and

Whereas, Those legislative efforts have not yet passed into law, which has resulted in continued confusion among physicians diagnosing and treating mental and behavioral health disorders regarding the circumstances under which it is permissible to prescribe controlled substances in the context of telemedicine; therefore be it

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

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

Received: 05/21/18
RELEVANT AMA POLICY

Coverage of and Payment for Telemedicine H-480.946

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:
   a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
      - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
      - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
   b) Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

   Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
   c) 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.
   d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
   e) The delivery of telemedicine services must be consistent with state scope of practice laws.
   f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
   g) The standards and scope of telemedicine services should be consistent with related in-person services.
   h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
   i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
   j) The patient's medical history must be collected as part of the provision of any telemedicine service.
   k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
   l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
   m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

The Promotion of Quality Telemedicine H-480.969

1. It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
   a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
      - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
      - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
   b) Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine.

   Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
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Whereas, Fewer medical students are opting to go into primary care, resulting in policy makers' approval of scope of practice expansion to develop physician substitutes to fill this void; and

Whereas, State policy makers face increasing pressure to expand the scope of practice of non-physician practitioners as a means to address the physician workforce shortages; and

Whereas, Scope of practice expansion is escalating and is often a top legislative priority for state and national physician associations; and

Whereas, Physician morale is declining, with 54% of physicians rating their morale as somewhat or very negative, and 49% experiencing feelings of burnout; and

Whereas, Popular workforce surveys/studies on state practice environments and physician morale and physicians' wellbeing often do not take into account the impact of scope of practice expansion on the physician workforce; and

Whereas, The impact of scope of practice expansion on non-physicians is known, the impact on the physician workforce is relatively unknown; and

Whereas, State policy makers and healthcare stakeholders contemplate investments to increase primary care providers, they should fully understand the implications of scope expansion policies that create physician substitutes on the supply of physicians and medical student decisions; therefore be it

RESOLVED, That our American Medical Association continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the inclusion of scope of practice expansion into measurements of physician well-being (New HOD Policy); and be it further
RESOLVED, That our AMA study the impact of scope of practice expansion on medical student decisions to enter into primary care. (Directive to Take Action)

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

Received: 06/02/18

References:
Whereas, The first Group Purchasing Organization (GPO) was formed in 1910 to reduce hospitals’ costs by buying supplies in bulk; and

Whereas, Under the GPO business model, members paid dues to cover administrative costs, which by design were less than the savings from bulk discounts; and

Whereas, In 1986 and 1987, Congress enacted the federal Anti-Kickback law and regulatory Safe Harbor provision exempting GPOs from criminal prosecution for taking kickbacks from suppliers, but by 1991, vendors—not hospitals—began paying GPO “administrative” expenses; and

Whereas, Today, GPOs extract a wide range of fees from the medical supply chain for the “privilege” of access to the market, with kickbacks often exceeding 50% of a supplier’s revenue for a single drug; and

Whereas, When the federal anti-kickback law and regulatory safe harbor was expanded further to Pharmacy Benefit Managers (PBMs) in 2001, PBMs began claiming coverage under the safe harbor provision in order to assert control over outpatient drugs and devices, which is resulting in shortages of basic life-saving drugs, exorbitant prices, and quality problems; therefore be it

RESOLVED, That our American Medical Association collaborate with medical specialty partners, patient advocacy groups, and other stakeholders to seek repeal of the 1987 Safe Harbor exemption to the Medicare Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and Pharmacy Benefit Managers (PBMs) (Directive to Take Action); and be it further

RESOLVED, That our AMA educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm Policy H-100.956, which states in part that “Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.” (Reaffirm HOD Policy)

Fiscal note: Modest – between $1,000 - $5,000.

Received: 06/09/18
Whereas, The Department of Homeland Security has announced a “zero tolerance” policy that requires that all unlawful border crossers be referred to the Department of Justice for prosecution as a misdemeanor of illegal entry, including parents seeking asylum from persecution who enter the U.S. with their children; and

Whereas, These children will be treated as if they were “unaccompanied minors,” separated from their parents and sent into facilities administered by the federal government; and

Whereas, A policy of universally separating children from their parents entering U.S. borders will do great harm to children, their parents, and their families; and

Whereas, Childhood trauma and adverse childhood experiences create negative health impacts that will last an individual’s entire lifespan; and

Whereas, Families seeking refuge in the U.S. already endure emotional and physical stress, and separating family members from each other only serves to dramatically exacerbate that stress; therefore be it

RESOLVED, That our American Medical Association oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child’s well-being (New HOD Policy); and be it further

RESOLVED, That our AMA urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families. (Directive to Take Action)

Fiscal note: Modest – between $1,000 - $5,000.

Received: 06/09/18
Whereas, A public charge is an individual who is “primarily dependent on the government for subsistence, as demonstrated by either (i) the receipt of public cash assistance for income maintenance, or (ii) institutionalization for long-term care at government expense;” and

Whereas, The Immigration and Nationality Act dictates that if an immigration and/or consular authority concludes that an individual is likely to become a public charge, that they should be ineligible for permanent legal status; and

Whereas, The Department of Homeland Security has proposed a rule change for publication in July 2018 to consider the use of non-cash benefits, such as Children’s Health Insurance Program (CHIP), when determining whether an individual will likely become a public charge; and

Whereas, The proposed rule change would also allow for consideration of non-cash public benefits used by dependent family members, including U.S. citizen children, in determining an individual’s eligibility to obtain permanent residence status; and

Whereas, Anti-immigrant policies contribute to decreased utilization of health care and social services such as Medicaid, prenatal care, and food stamps, and thus exacerbate health disparities and illnesses in immigrant populations; and

Whereas, Health care workers across the country have reported recent trends in which immigrants with and without U.S. citizen children that are pursuing permanent residency are not utilizing health care and other social services, for fear that utilizing these services will jeopardize their chances of obtaining documentation to stay in the U.S.; therefore be it

RESOLVED, That our American Medical Association, upon the release of proposed rule or regulation that would deter immigrants and/or their dependents from utilizing non-cash public benefits including Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition; and be it further
RESOLVED, That our AMA amend AMA policy H-20.901 by addition to read as follows:

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

Fiscal note: Modest – between $1,000 - $5,000.

Date Received: 06/09/18

References:


RELEVANT AMA POLICY
Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968
Improving the Health of Black and Minority Populations H-350.972
Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
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
317# Emerging Technologies (Robotics and AI) in Medical School Education
318# AMA Convene Stakeholders to Transition USMLE to Pass / Fail Scoring
319* All Payer Graduate Medical Education Funding
320* Young Physician Involvement in Maintenance of Certification

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(A-18)

Introduced by: Arizona
Subject: All Payer Graduate Medical Education Funding
Referred to: Reference Committee C
(Sherrri Baker, MD, Chair)

Whereas, Graduate medical education (residency) is essential for medical school graduates to acquire the additional skills needed, and to be licensed to practice medicine; and

Whereas, The number of medical school graduates in the US now exceeds the number of residency positions; and

Whereas, All types of medical insurance (original Medicare, Medicare Advantage, Medicaid and all forms of commercial insurance) require trained physicians to provide care to their beneficiaries; and

Whereas, Almost all residency positions in the US are funded by Medicare and Medicaid, and not by commercial insurers; and

Whereas, There is geographic misdistribution of residency positions relative to medical schools; and

Whereas, The AMA recognized this issue and created Policy D-305.973 to address this at the 2005 Annual Meeting meeting and last reaffirmed it at the 2013 Annual Meeting; and

Whereas, The AMA recognized that this was still an issue in 2007, and created Policy D-305.967 to address this at the 2007 Annual Meeting, and last reaffirmed it at the 2017 Annual Meeting; and

Whereas, The problems of underfunding, inadequate number of residencies and geographic misdistribution of residencies continue to worsen; therefore be it

RESOLVED, That our American Medical Association investigate the status of implementation of AMA Policies D-305.973, “Proposed Revisions to AMA Policy on the Financing of Medical Education Programs” and D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education” and report back to the House of Delegates with proposed measures to resolve the problems of underfunding, inadequate number of residencies and geographic maldistribution of residencies. (Directive to Take Action)

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

Received: 06/02/18

RELEVANT AMA POLICY

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs D-305.973
Our AMA will work with:
(1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
(a) ensure adequate Medicaid and Medicare funding for graduate medical education;
(b) ensure adequate Disproportionate Share Hospital funding;
(c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
(d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
(e) stabilize funding for pediatric residency training in children's hospitals;
(f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need;
(g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
(h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and
(2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

Citation: (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will 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. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
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.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately
work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation’s current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program’s sponsoring institution.
15. Our AMA 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.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will 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. Our AMA 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.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. 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.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.

32. Our AMA will advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 320
(A-18)

Introduced by: Young Physicians Section

Subject: Young Physician Involvement in Maintenance of Certification

Referred to: Reference Committee C
(Sherri Baker, MD, Chair)

Whereas, Young physicians report feeling disenfranchised with the current Maintenance of Certification (MOC) system; and

Whereas, Young physicians represent the future of medicine and have the most vested interest in maintaining quality of MOC; and

Whereas, At least one specialty board excludes young physicians from service on the board of directors and another requires directors to be “of mature age”; and

Whereas, The American Board of Medical Specialties recently launched the initiative “Continuing Board Certification: Vision for the Future” and is seeking comments from stakeholders; therefore be it

RESOLVED, That our American Medical Association submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the ABMS and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards. (Directive to Take Action)

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

Received: 06/09/18

RELEVANT AMA POLICY

Maintenance of Certification and Osteopathic Continuous Certification D-275.954

References:
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 Warning
426# Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs
427# Support Gun Buyback Programs in Order to Reduce the Number of Circulating Unwanted Firearms
428# LGBTQIA+ Inclusive Sex Education Alongside Heterosexual Sex Education
429# E-Cigarette Ingredients
430# Vector-Borne Diseases
431# Low Nicotine Cigarette Product Standard

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
Reference Committee D

Resolution(s)

432# Legal Action to Compel FDA to Regulate E-Cigarettes
433# Firearm Safety
434* Health Care Workplace Ergonomics

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
Whereas, Physicians work long hours, often finding themselves in cramped, awkward positions as they hold human life in their hands; and

Whereas, Recent studies suggest that this stress adds up and can frequently manifest into insidious pain that results in temporary, and in some cases permanent, work-related musculoskeletal disorders (MSD);¹ and

Whereas, While many work-related MSDs experienced by the medical workforce are multifactorial—especially as the workforce ages—subpar instrument design has also been identified as a contributing factor to the wear and tear on physicians’ bodies;² and

Whereas, The problem has become so significant that some experts have referred to it as "an impending epidemic," and fear that it may contribute to the projected shortage of surgeons in coming years;³ and

Whereas, Despite the prevalence of such work-related MSDs among physicians, it continues to receive little attention because of the logistical constraints of studying surgical ergonomics, physicians under-reporting injuries and lacking awareness of applied ergonomics recommendations; and

Whereas, Improved education and interventions on ergonomics have the ability to improve physician health, especially in the surgical and interventional specialties; therefore be it

RESOLVED, That our American Medical Association: (1) support research on reducing physician and staff ergonomic injuries in the health care workplace, including but not limited to studying medical instrument and work station design and development; and (2) work with resident training programs, hospitals and other interested parties to help integrate evidence-based ergonomics programs with other types of wellness programs for physicians and medical staffs (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for legislation that would: (1) appropriate an adequate percentage of research dollars to National Institutes of Health (NIH), NIH Institutes, National Science Foundation (NSF), The National Institute for Occupational Safety and Health (NIOSH), and National Academy of Medicine for basic and advanced research of health care workplace ergonomics; and (2) require that such research be focused on practicing physicians, with practicing physicians as Principal Investigators. (Directive to Take Action)

Fiscal note: Modest – between $1,000 - $5,000.

Received: 06/09/18
REFERENCES


³ Ibid.
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
518# Portable Listening Devices and Noise Induced Hearing Loss
519# Warning Labels for Children's Digital and Video Games
520# Handling of Hazardous Drugs
521# EPA Glider Truck Standard
522# Silence Science: EPA Proposed Data Policy
523* Biosimilar Interchangeability Pathway
524* Naloxone on Commercial Airlines
525* Tramadol Change from DEA Schedule IV to Schedule III
526* Direct to Consumer Laboratory Testing

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
Whereas, Safe and effective treatments should be available to patients at the lowest possible cost; and

Whereas, Biosimilars are medicines that could be cost-saving alternatives for specialty drugs called biologics, which are large, complex therapeutic agents typically given by an injection or infusion. The relationship between biosimilars and biologics, at the regulatory but not biochemical level, is akin to the relationship between generic and brand name medicine, though biosimilars are not generic copies of their reference drugs; and

Whereas, The size, complexity, and heterogeneity of biologics, and thus biosimilars, necessitate a greater degree of scrutiny in their analytical evaluation than what is required for small molecule generics. Due to the complexity of biologics, separate regulatory approval and dispensing pathways were created to ensure effectiveness and protect patient safety; and

Whereas, In addition to adequate pharmacokinetic and pharmacodynamics studies, clinical data are necessary to ensure the safety and efficacy of biosimilars, and to provide the necessary level of confidence for their use by patients and providers; and

Whereas, Congress authorized the FDA to provide two pathways for biosimilar approval: 1) biosimilar agents that have equivalent safety, purity, and potency as original biologics; and 2) a higher level of interchangeable biosimilars in which alternating or switching between an original biologic and biosimilar would not be predicted to cause any changes in efficacy or safety; and

Whereas, Most state legislatures have passed laws that will allow substitution of an interchangeable biosimilar for a reference product, with the necessary notification of the prescriber to ensure patients receive drugs consistent with their provider’s treatment plan; and

Whereas, The FDA must ensure that regular and interchangeable biosimilars are safe and effective. In January 2017 the FDA released draft guidance outlining requirements for manufacturers to use robust switching studies to determine whether alternating between a biosimilar and its reference product impacts the safety or efficacy of the drug; and

Whereas, The requirement for multiple-switch studies to demonstrate the safety of interchangeability is particularly vital to proper enforcement of the law, which requires studying “alternating” or repeatedly switching; therefore be it
RESOLVED, That our American Medical Association strongly support the rigorous pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug (New HOD Policy); and be it further

RESOLVED, That our AMA issue a request to the FDA that the agency finalize the biosimilars interchangeability pathway outlined in its draft guidance “Considerations in Demonstrating Interchangeability With a Reference Product” with all due haste, so as to allow development and designation of interchangeable biosimilars to proceed, allowing transition to an era of less expensive biologics that provide safe, effective, and accessible treatment options for patients. (Directive to Take Action)

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

Received: 05/25/18

RELEVANT AMA POLICY

Biosimilar Product Naming and Labeling D-125.987
Our AMA urges the FDA to finalize Guidance on the naming and labeling conventions to be used for biosimilar products, including those that are deemed interchangeable. Any change in current nomenclature rules or standards should be informed by a better and more complete understanding of how such changes, including requiring a unique identifier for biologic USANs would impact prescriber attitudes and patient access, and affect post marketing surveillance. Actions that solely enhance product identification during surveillance but act as barriers to clinical uptake are counterproductive. However, because of unique product attributes, a relatively simple way to identify and track which biosimilar products have been dispensed to individual patients must be established. If unique identifiers for biosimilar USANs are required to support pharmacovigilance, they should be simple and the resulting names should reinforce similarities by using the same root name following standards for nonproprietary names established by the USAN Council.
CSAPH Rep. 4, A-14

Substitution of Biosimilar Medicines and Related Medical Products D-125.989
Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena: (1) preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients; (2) allow substitution when physicians expressly authorize substitution of an interchangeable product; (3) limit the authority of pharmacists to automatically substitute only those biosimilar products that are deemed interchangeable by the FDA.
Citation: (Res. 918, I-08; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14)

Abbreviated Pathway for Biosimilar Approval H-125.980
Our AMA supports FDA implementation of the Biologics Price Competition and Innovation Act of 2009 in a manner that 1) places appropriate emphasis on promoting patient access, protecting patient safety, and preserving market competition and innovation; 2) includes planning by the FDA and the allocation of sufficient resources to ensure that physicians understand the distinctions between biosimilar products that are considered highly similar, and those that are deemed interchangeable. Focused educational activities must precede and accompany the entry of biosimilars into the U.S. market, both for physicians and patients; and 3) includes compiling and maintaining an official compendium of biosimilar products, biologic reference products, and their related interchangeable biosimilars as they are developed and approved for marketing by the FDA.
Citation: (Res. 220, A-09; Reaffirmation A-11; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14)
Whereas, The AMA, physicians, the public; and legislators have expressed great concern about morbidity and mortality associated with opioid drug overdose, which is high and continuing to increase in the United States; and

Whereas, The number of deaths from drug overdose involving opioid analgesics has increased more rapidly than deaths involving any other type of drug; and

Whereas, Naloxone is a safe and effective US Food and Drug Administration- (FDA) approved drug used to reverse the effects of opioid overdose; and

Whereas, Naloxone is already carried by many first responders, with the U.S. Surgeon General having recently issued a health advisory urging more Americans to carry naloxone, in order to temporarily suspend the effects of the overdose until emergency responders arrive; and

Whereas, The AMA supports legislative, regulatory; and national advocacy efforts to increase access to affordable naloxone; and

Whereas, Handling an opioid overdose has become almost commonplace at hospitals across the country; and

Whereas, Physicians traveling on commercial aircraft are frequently asked to respond to medical events onboard aircraft; and

Whereas, Liability protections exist for physicians and other health care professionals who prescribe, dispense and/or administer medical care onboard aircraft (the Good Samaritan Act); and

Whereas, The Federal Aviation Administration (FAA) requires commercial air carriers to carry onboard emergency medical kits; and

Whereas, Naloxone is not currently included in the FAA-required emergency medical kit; and

Whereas, Airlines may include FDA-approved medications in medical kits without being required by the FAA to do so; and

Whereas, The Association of Flight Attendants and the major pharmaceutical manufacturer of naloxone are in favor of providing naloxone in the airline medical kit; therefore be it
RESOLVED, That our American Medical Association support the addition of naloxone to the airline medical kit (New HOD Policy); and be it further

RESOLVED, That our AMA encourage airlines to voluntarily include naloxone in their airline medical kits (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the addition of naloxone to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits). (New HOD Policy)

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

Received: 06/02/18
Whereas, The death rate from overdoses of all opioids has increased 429% from 8,050 in 1999
to 42,249 in 2016, and the death rate from synthetic opioids, including tramadol and fentanyl
and its derivatives, has increased more than 2,000% from 730 in 1999 to 19,413 in 2016; and

Whereas, Emergency Department visits for misuse or abuse of tramadol have increased 230%
from 6,255 visits in 2005 to 21,649 visits in 2011; and

Whereas, Tramadol is an opioid agonist, with complex pharmacology, and the US Drug
Enforcement Administration (DEA) lists tramadol in Schedule IV, which should “have a low
potential for abuse relative to substances in Schedule III”; and

Whereas, Codeine with acetaminophen is listed in Schedule III by the DEA, and codeine, as a
single entity, is listed in Schedule II; and

Whereas, Some studies suggest that tramadol has similar abuse potential as certain Schedule II
narcotics including codeine; and

Whereas, The DEA allows medical societies to petition for a change in Schedule of a controlled
substance; therefore be it

RESOLVED, That our American Medical Association petition the United States Drug
Enforcement Administration to change tramadol from a Schedule IV to a Schedule III controlled
substance. (Directive to Take Action)

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

Received: 06/02/18

References
cdc.gov/nchs/products/databriefs/db294.htm
2. DM Bush, The DAWN Report: Emergency Department Visits for Drug Misuse or Abuse Involving the Pain Medication Tramadol,
3. TL Yaksh and MS Wallace. Opioids, Analgesia and Pain Management, in Goodman and Gilman’s Pharmacological Basis of
4. Tramadol Hydrochloride Tablets, Package Insert, revised August 2004
5. US Department of Justice - Drug Enforcement Administration. Definition of Controlled Substance Schedules.
https://www.deadiversion.usdoj.gov/schedules/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3594406/
Whereas, Direct-to-consumer (DTC) laboratory testing, also referred to as direct access testing, allows individuals to initiate their own laboratory tests without an order from, or consultation with, a physician or other health care provider; and

Whereas, In the United States, DTC laboratory testing is regulated at both the federal and state level; and

Whereas, At the federal level, The Centers for Medicare & Medicaid Services (CMS) ensures the accuracy and reliability of all laboratory tests performed on humans in the United States through the Clinical Laboratory Improvement Amendments (CLIA); and

Whereas, Although CMS enforces regulatory requirements for analytical validity under CLIA, it does not have the authority to enforce requirements for the clinical validity of DTC laboratory tests; and

Whereas, Further, many facilities that offer DTC lab testing are not required to be CLIA-certified due to their ability to claim exemption from regulatory oversight by asserting that they provide “health information,” not diagnostic test results; and

Whereas, At the state level, the availability of DTC laboratory testing and the range of tests offered vary according to each state’s laboratory laws; and

Whereas, Although certain DTC lab tests (e.g., lipid panel or profile to check cholesterol levels), if conducted by properly certified laboratories through companies that provide for licensed physicians to explain the results to patients, may raise few red flags, those companies that are not properly certified due to gaps in federal and state oversight may ultimately put patients at risk for harm; and

Whereas, State and federal guidance and regulations that effectively close gaps in the oversight of DTC laboratory testing must be developed in order to minimize the harms and maximize the benefits of DTC laboratory testing; and

Whereas, It is also vital that patients not only receive complete, accurate, and balanced information that describes the benefits, risks, and limitations of DTC laboratory tests, but also continue being educated on the importance of consulting with a physician to select the appropriate tests and interpret all results; therefore be it
RESOLVED, That our American Medical Association: (1) advocate for vigilant oversight of
direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2)
encourage physicians to educate their patients about the risks and benefits of DTC laboratory
tests, as well as the risks associated with interpreting DTC test results without input from a
physician or other qualified health care professional. (Directive to Take Action)

Fiscal Note: Moderate – between $1,000 - $5,000.

Received: 06/09/18
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
  43* American Podiatric Medical Association Request for Official Observer Status in the House of Delegates

HOD Comm on Compensation of the Officers
  01# Report of the HOD Committee on Compensation of the Officers

Resolution(s)
  601  Creation of LGBTQ Health Specialty Section Council
  602  Health Fitness Partnerships
  603  Eliminating Food Waste Through Recovery
  604  AMA Delegation Entitlements
  605# Practicing Physician Declining Membership Analysis
  606# Training Physicians in the Art of Public Forum
  607# Discounted / Waived CPT Fees as an AMA Member Benefit and for Membership Promotion
  608* Divestment from Companies Whose Primary Business is Fossil Fuel

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
The Board of Trustees has received a request from the American Podiatric Medical Association (APMA) to be considered for Official Observer status in the House of Delegates. The APMA’s request has been thoroughly considered using the criteria below (Policy G-600.025, “Official Observers in Our AMA House”):

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both;
2. The organization should be national in scope and have similar goals and concerns about health care issues;
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD; and
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The Board has discussed the APMA’s request, and presents the following report.

DISCUSSION

As part of its request, APMA submitted information on how it has met the criteria for Official Observer status, which is summarized below.

Criterion 1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.

APMA has hosted representatives of the AMA at its House of Delegates meeting for over a decade, and invite the AMA representative to its President’s Dinner and offer the representative an opportunity to address the APMA House. Dr. Barbe participated in the APMA meeting this year. As a result of these interactions, there have been numerous opportunities to work collaboratively. When he was AMA President and Co-Chair of the Commission to End Healthcare Disparities, Dr. Jeremy Lazarus invited APMA to participate in the Commission. APMA was an active participant, and an APMA representative sat on the Commission’s steering committee and co-chaired one of its committees. APMA was also an active participant in the Physician Consortium for Performance Improvement, and is a current member of the PCPI Foundation.
In addition, APMA participates on the AMA/Specialty Society Relative Value Scale Update Committee (RUC) as part of the Health Care Professionals Advisory Committee (HCPAC) Review Board, and as such regularly collaborates with specialty societies with shared interests (e.g., American College of Surgeons, American College of Radiology, American Academy of Orthopaedic Surgeons). The APMA’s RUC liaisons have previously served as HCPAC Chair, on the RUC’s Practice Expense Subcommittee, and Research Subcommittee. APMA also actively participates on the CPT HCPAC.

Last, APMA’s state component societies collaborate and regularly meet with state medical associations on shared health care issues. One example is the strong collaborative relationship forged between the California Medical Association and its California podiatric counterpart.

**Criterion 2. The organization should be national in scope and have similar goals and concerns about health care issues.**

The APMA was founded in 1912, and represents a majority of the nearly 18,000 podiatrists in the U.S. APMA has 53 state and territorial component societies. Its mission is to advance and advocate for the specialty of podiatric medicine and surgery for the benefit of its members and the health of the public.

The APMA has similar health reform goals as the AMA, among them universal access and coverage, coverage expansion through a mixture of public and private funding and delivery sources, protection of the patient-physician relationship, support for programs and facilities that serve underserved populations, and tort reform.

The APMA also shares many of the AMA’s concerns with regard to payment reform, and has offered the Centers for Medicare and Medicaid Services similar comments regarding such issues, including MIPS and APMs.

**Criterion 3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD.**

As the national organization representing the majority of US podiatrists, the APMA would bring podiatrists’ unique perspectives to the House.

**Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.**

The APMA does not represent narrow religious, social, cultural, economic, or regional interests. It has a diverse membership, and its members represent the spectrum of practice types. The APMA works collaboratively with the AMA, state and specialty societies, and the vast majority of its interests align with those of the AMA. Scope of practice issues have occasionally arisen, but on other issues, there has been strong alignment and collaborative work. It should also be noted that podiatry has made significant changes to its educational standards, including the standardization of a three-year hospital based residency in addition to the four-year undergraduate curriculum. Podiatrists also work collaboratively with physicians on a day-to-day basis, particularly within multi-specialty practices.

**DISCUSSION**
The Board of Trustees appreciates the fact that the APMA has already sent representatives to AMA House of Delegates meetings for over 20 years. As part of its review, the Board made informal inquiries with relevant specialty delegations in the House, and received positive responses with regard to the reception of APMA as an Official Observer. The Board thus believes that the APMA should be recognized as an Official Observer and welcomed to the House in that capacity.

RECOMMENDATION

The Board of Trustees recommends that the American Podiatric Medical Association be admitted as an Official Observer in the House of Delegates, and that the remainder of this report be filed.

Fiscal Note: Under $500
Appendix - Official Observers to the House of Delegates

<table>
<thead>
<tr>
<th>Organization</th>
<th>Year Admitted</th>
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<tbody>
<tr>
<td>Accreditation Association for Ambulatory Health Care</td>
<td>1993</td>
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<td>Alliance for Continuing Medical Education</td>
<td>1999</td>
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<td>Alliance for Regenerative Medicine</td>
<td>2014</td>
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<td>Ambulatory Surgery Center Association</td>
<td>2005</td>
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<td>American Academy of Physician Assistants</td>
<td>1994</td>
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<td>American Association of Medical Assistants</td>
<td>1994</td>
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<td>American Board of Medical Specialties</td>
<td>2014</td>
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<td>American Dental Association</td>
<td>1982</td>
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<td>American Health Quality Association</td>
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<td>American Hospital Association</td>
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<td>American Nurses Association</td>
<td>1998</td>
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<td>American Public Health Association</td>
<td>1990</td>
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<td>Association of periOperative Registered Nurses</td>
<td>2000</td>
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<td>Association of State and Territorial Health Officials</td>
<td>1990</td>
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<tr>
<td>Commission on Graduates of Foreign Nursing Schools</td>
<td>1999</td>
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<tr>
<td>Council of Medical Specialty Societies</td>
<td>2008</td>
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<td>Educational Commission for Foreign Medical Graduates</td>
<td>2011</td>
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<td>Federation of State Medical Boards</td>
<td>2000</td>
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<td>Federation of State Physician Health Programs</td>
<td>2006</td>
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<td>Medical Group Management Association</td>
<td>1988</td>
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<tr>
<td>National Association of County and City Health Officials</td>
<td>1990</td>
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<tr>
<td>National Commission on Correctional Health Care</td>
<td>2000</td>
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<tr>
<td>National Council of State Boards of Nursing</td>
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<tr>
<td>National Indian Health Board</td>
<td>2013</td>
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<td>PIAA</td>
<td>2013</td>
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<tr>
<td>Society for Academic Continuing Medical Education</td>
<td>2003</td>
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<td>US Pharmacopeia</td>
<td>1998</td>
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</table>
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608  
(A-18)

Introduced by:  American Association of Public Health Physicians

Subject:  Divestment from Companies Whose Primary Business is Fossil Fuel

Referred to:  Reference Committee F  
(Julia V. Johnson, MD, Chair)

Whereas, The Intergovernmental Panel on Climate Change has concluded that the burning of fossil fuels by humans to generate energy is the principal driver of climate change. Burning fossil fuels is already causing accelerated warming of Earth’s surface, which is a direct threat to both environmental and human health; and

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

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

Whereas, Our AMA recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public (H-135-938); and

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

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

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

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

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

Fiscal Note: Undeterminable

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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
712# Alternative Payment Models and Vulnerable Populations
713# Private Equity Firms
714# Laboratory Benefit Managers
715* The Obligatory Nature and Enduring Purpose of the Self-Governed Organized Medical Staff
716* Hospital Closures and Physician Credentialing
717* Impact of the High Capital Cost of Hospital EHRs on the Medical Staff

# Contained in the Handbook Addendum
* Contained in the Sunday Tote
whereas, For more than 50 years, the contribution of physicians to the quality of hospital care through an organized medical staff has been recognized in Medicare Conditions of Participation, accreditation standards and hospital licensing rules; and

whereas, Our health care system has not only undergone drastic changes within two generations, but also continues to evolve and impact the delivery of health care, as well as the relationship between physicians and hospitals; and

whereas, These changes have led many in the medical community to call into question the relevance of the organized medical staff structure; and

whereas, Despite the over 160 policies and directives on medical staff topics, including a comprehensive abridgement of the rights and responsibilities of the organized medical staff, the AMA has no policy that unequivocally establishes the obligatory nature and enduring purpose of the self-governed organized medical staff; therefore be it

Resolved, That our American Medical Association amend Policy H-225.942 by addition to read as follows:

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients give rise to a heightened and incomparable accountability to patients that is not shared by hospital administrators or members of the
governing body. This unparalleled accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients’ best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:
   a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization’s governing body.
   b. The responsibility to provide leadership and work collaboratively with the health care organization’s administration and governing body to continuously improve patient care and outcomes.
   c. The responsibility to participate in the health care organization’s operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
   d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
   e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
   f. The responsibility to make appropriate recommendations to the health care organization’s governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities:
   a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
   b. The right to advocate for its members and their patients without fear of retaliation by the health care organization’s administration or governing body.
   c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
   d. The right to be well informed and share in the decision-making of the health care organization’s operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
e. The right to be represented and heard, with or without vote, at all meetings of the health care organization’s governing body.

f. The right to engage the health care organization’s administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

a. The responsibility to work collaboratively with other members and with the health care organization’s administration to improve quality and safety.

b. The responsibility to provide patient care that meets the professional standards established by the medical staff.

c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.

e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.

f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization’s administration or governing body.

d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy)

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

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Whereas, Hospital closures are becoming increasingly common in the United States; and
Whereas, These closures have the potential to cause upheaval among patients, physicians and other healthcare providers in the market; and
Whereas, After the closure of a hospital, other hospitals and other organizations that credential physicians often experience difficulty accessing verified credentialing information for physicians who were on staff at the now-closed hospital; and
Whereas, Delays in privileging and credentialing due to inaccessibility of historical credentialing information can have a devastating effect on displaced physicians and residents alike; therefore be it
RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the AMA Organized Medical Staff Section and National Association Medical Staff Services, to produce an AMA credentialing repository that would allow hospitals and other organizations that credential physicians to access verified credentialing information for physicians who were on staff at a hospital, or one of its departments, at the time of closure, and report back at the 2018 Interim Meeting. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 06/09/18

RELEVANT AMA POLICY

H-230.956 Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records
1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows:

A. Governing Body to Make Arrangements: The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility.
B. Transfer to New or Succeeding Custodian: Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to
make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.

C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.

D. Maintenance and Retention: Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records.

E. Access and Fees: The new custodian of the records shall provide access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.

2. Our AMA advocates for the implementation of this policy with the American Hospital Association. (Res. 808, I-04 Reaffirmed: CMS Rep. 1, A-14)
Whereas, Hospitals and other health care institutions are facing huge costs in the installation of
electronic health records (EHRs) and related health information technology; and

Whereas, For independent practices, the exorbitant cost of purchasing, installing and
maintaining EHR software to achieve interoperability has left physicians, particularly specialists,
with little option but to merge into a hospital system; and

Whereas, For example, in Massachusetts, EPIC has become a common choice for hospital-
based EHRs, and its high cost makes installing it in community practices impractical from a
financial point of view—even if the practices have been acquired by the hospital; and

Whereas, Enterprise-wide EHR systems have created huge capital outlays and larger budget
deficits for interoperable hospital systems, rivaling the capital costs of entire budgets for new
facilities and equipment at many institutions; and

Whereas, Recently, hospital staff physicians and nurses have been “laid off” or dismissed at an
alarming rate because of the enormous investments in hospital EHRs; and

Whereas, These expenditures have resulted in the destabilization of hospital finances with
many institutions ending up in the “red,” leading to a downgrade of the hospital bond ratings and
the pressure to “balance the books;” and

Whereas, The absolute magnitude of EHR-related expenses has increased to an extent that a
return on investment may not be feasible given the costs associated with maintaining and
upgrading EHR software; and

Whereas, While the AMA has policy on EHR adoption that continues to guide its physician
satisfaction strategic priority efforts, the AMA has no policy that addresses the impact of
hospitals investing massive amounts of money on EHRs, and its effect on medical staffs,
especially when considering physician recruitment and retention; therefore be it

RESOLVED, That our American Medical Association study the long-term economic impact for
physicians and hospitals of EHR system procurement, including but not limited to their impact
on downsizing of medical staffs and its effect on physician recruitment and retention. (Directive
to Take Action)

Fiscal Note: Moderate: Estimated cost to implement resolution is $10,000.

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