

ONLINE MEMBER FORUM

REFERENCE COMMITTEE B REPORT

INTERIM MEETING
2018

Roger Brown

BOT 4 - Increased Use of Body-Worn Cameras by Law Enforcement Officers

The Board recommends that the following be adopted in lieu of Resolution 208-I-17, and that the remainder of the report be filed.

- That our American Medical Association work with interested state and national medical specialty societies to support state legislation and/or regulation that would encourage the use of body-worn camera programs for law enforcement officers and fund the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies.

Rohan Rastogi

RE: BOT 4 - Increased Use of Body-Worn Cameras by Law Enforcement

- Rohan Rastogi, Alternate Delegate from Massachusetts, speaking on behalf of the Medical Student Section, **in support** of the Board of Trustees' recommendation.
- As original authors of the resolution prompting the report, we appreciate the BOT's thorough review of the evidence on body-worn camera programs for law enforcement officers. Several studies have shown that police use-of-force against civilians declined after implementation of body-worn cameras. Furthermore, civilians filed fewer complaints against law enforcement officers following implementation. As such, body-worn cameras evidently carry benefits for civilians and police officers alike.
- Though some may raise concerns that action on this topic lies outside the scope of the AMA, there are potential health implications of policies in support of body-worn cameras. Some studies show that police use-of-force is associated with increased stress, anxiety, PTSD, and poor overall health (high

blood pressure, diabetes, and asthma). The decreased use-of-force seen with body-worn cameras could counteract these negative health impacts.

- In summary, the Medical Student Section is in support of the BOT recommendation that the AMA work with medical specialty societies to support state policies that would promote body-worn camera use. We thank the BOT for their diligence and time in producing this report.
- Opinion Type:
- My post reflects the opinion of my delegation or section
- Signature Name:
- Rohan Rastogi (rrastogi@bu.edu)
- Delegation section or society:
- Medical Student Section

Roger Brown

BOT 5 - Exclusive State Control of Methadone Clinics

The Board recommends that the following recommendation be adopted in lieu of Resolution 211-I-17, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the right of federally certified Opioid Treatment Programs (OTPs) to be located within residential, commercial and any other areas where there is a demonstrated medical need; (New HOD Policy)
2. That our AMA encourage state governments to collaborate with health insurance companies and other payers, state medical societies, national medical specialty societies, OTPs and other health care organizations to develop and disseminate resources that identify where OTP providers operate in a state and take part in surveillance efforts to obtain timely and comprehensive data to inform treatment opportunities; and (New HOD Policy)
3. That our AMA advocate for the federal agencies responsible for approving opioid treatment programs to consider the views of state and local stakeholders when making decisions about OTP locations and policies. (New HOD Policy)

DAVID WELSH

RE: BOT 5 - Exclusive State Control of Methadone Clinics

I support the report. It can be improved by calling on methadone clinics to report to state controlled substances panels.

Opinion Type:

My post is my personal opinion

Roger Brown

BOT 7 - Advocacy for Seamless Interface Between Physicians Electronic Health Records (EHRs), Pharmacies and Prescription Drug Mo

The Board of Trust recommends that the following recommendations be adopted in lieu of Resolution 212-A-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying whether PDMPs can distinguish team-based care from uncoordinated care, misuse, or “doctor shopping,” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. (Directive to Take Action)
2. That our AMA urge EHR vendors to increase transparency of custom connections and costs for physicians to integrate their products in their practice. (Directive to Take Action)
3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. (New HOD Policy)

Roger Brown

BOT 8 - 340B Drug Discount Program

In light of these considerations, your Board of Trustees recommends that the following recommendations be adopted in lieu of the third resolve Resolution 225-A-18 and the remainder of this report be filed:

1. That our American Medical Association support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices. (New HOD Policy)
2. Our AMA will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program. (Directive to Take Action)

Roger Brown

BOT 11 - Violence Prevention

The Board of Trustees recommends that the following recommendations be adopted in lieu of the first and third resolves of Resolution 419-A-18 and the remainder of the report be filed.

1. That Policy H-145.996, "Firearm Availability" be amended by addition and deletion to read as follows:

H-145.996 Firearm Availability

1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
 2. Our AMA ~~policy is to~~ supports requiring ~~require~~ the licensing/permitting of ~~owners of firearms~~ owners and purchasers, including the completion of a required safety course, and registration of all firearms.
 3. Our AMA supports granting local law enforcement discretion over whether to issue concealed carry permits. ~~in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding "concealed carry", by supporting "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and by supporting "red flag" laws for individuals who have demonstrated significant signs of potential violence.~~ In supporting local law enforcement, we also support as well the importance of "due process" so that ~~decisions could be reversible by individuals~~ can petition ~~petitioning in court~~ for their rights to be restored. (Modify Current HOD Policy)
2. That Policy H-145.972, "Firearms and High-Risk Individuals" be reaffirmed.

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (Reaffirm HOD Policy)

3. That our American Medical Association: (1) encourages the enactment of state laws requiring the reporting of relevant mental health records, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of mental health records to NICS to improve the quality and timeliness of the data. (New HOD Policy)

Resolution: 11

Rachel Ekaireb

RE: BOT 11 - Violence Prevention

Rachel Ekaireb, Delegate from California speaking on behalf of the Medical Student Section in support of BOT report 11. The recommendations in this report are in alignment with multiple existing MSS policies, which support “strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases” (145.001MSS) and supports “strengthening the National Instant Criminal Background Check System (NCIS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves AMA-MSS Digest of Policy Actions/ 30 145.014MSS or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit” (145.013MSS). We commend the Board for the thorough review on this topic and believe it identifies concrete, actionable steps forward.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Rachel Ekaireb

Delegation section or society:

Medical Student Section

Resolution 201

Carla Frenzel

Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application

RESOLVED, That our American Medical Association develop model state legislation for physicians being credentialed by a health plan to treat patients and retroactively receive payments if they are ultimately credentialed.

Stephen Rockower

RE: Reimbursement for Services Rendered During Pendency of Physi

Medicare already does this. It would be very advantageous for young physicians to take advantage of this, to help them establish their practices.

Opinion Type:

My post is my personal opinion

GERALD CALLAS

RE: Reimbursement for Services Rendered During Pendency of Physi

Resolution 201

Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application

(Virginia)

The Texas Delegation strongly supports this concept. Delays in credentialing physicians for managed care organizations can be devastating to a practice's finances

as well as to the new physician who is waiting to be paid for services performed. Our surveys show that practice viability is one of our members' most serious concerns.

However, we believe we have a stronger proposal than this resolution's request for model state legislation that would provide retroactive payment to physicians if they are ultimately credentialed. In 2007, the Texas Medical Association worked with the Texas Legislature to pass a "deemed credentialed" law. Under this law, when a physician joins a group practice that already has a contract with a health plan, that physician is deemed to be credentialed once he or she has submitted an application. At that point, Texas law states, the health plan "shall treat the applicant physician as if the physician were a participating provider in the health benefit plan network when the applicant physician provides services to the managed care plan's enrollees, including (1) authorizing the applicant physician to collect copayments from the enrollees; and (2) making payments to the applicant physician."

We recommend that the reference committee substitute the Virginia language with the following language, or add a second resolve to state:

RESOLVED, That our AMA develop model state legislation for physicians being credentialed by a health plan, when they are part of a group practice with an existing contract with that health plan, to be deemed credentialed for purposes of payment for services that physician provides to that plan's enrollees.

We also recommend that the title of this resolution be changed to read:

Payment for Services Rendered During Pendency of Physician's Credentialing Application

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

GERALD CALLAS

Delegation section or society:

Texas Medical Association

WILLIAM REHA

RE: Reimbursement for Services Rendered During Pendency of Physi

Thanks for your comments on this resolution and appreciate the support. As author, I look forward to hearing your testimony at Ref Comm B. Question, How does Texas help those physicians who do not want to join a group, but instead may want to enter solo practice?

Opinion Type:

My post is my personal opinion

DAVID WELSH

RE: Reimbursement for Services Rendered During Pendency of Physi

I support the resolution. With Dr Rockower's comments, perhaps a call for education on available remedies could be included.

Opinion Type:

My post is my personal opinion

WILLIAM REHA

RE: Reimbursement for Services Rendered During Pendency of Physi

Thanks for your support!

Opinion Type:

My post is my personal opinion

Resolution 202

Carla Frenzel

Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings

RESOLVED, That our American Medical Association identify and work to remove those administrative and/or legal barriers that hamper the ability of primary care providers to prescribe methadone, through all appropriate legislative and/or regulatory means possible; and be it further

RESOLVED, That our AMA, working with other federation stakeholders, identify the appropriate educational tools that would support primary care physicians to provide ongoing methadone treatment for appropriate patients.

GERALD CALLAS

RE: Enabling Methadone Treatment of Opioid Use Disorder in Prima

Resolution 202

Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
(Pennsylvania)

The Texas Delegation understands the crucial need to expand the availability of treatment for opioid use disorder. Although recent statistics indicate a continued downward trend in deaths from drug overdoses in this country, and the passage this month of the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, we need to continue to array as many resources as possible against this scourge.

We agree that it is appropriate for primary care physicians who have undergone training for buphenorphine treatment to provide and supervise methadone treatment for opioid use disorder. We are concerned however, about the potential for unsupervised advance practice registered nurses (APRNs) and other nonphysician practitioners (who believe they are capable of doing anything a

primary care physician can do) of wanting to “get in on the action” without having the skills, training, or experience to monitor and recognize the broad, multi-systemic impact of this disorder and this treatment protocol.

We urge the reference committee to add language to this resolution stating that it is inappropriate for unsupervised APRNs and other nonphysician practitioners to prescribe methadone.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

GERALD CALLAS

Delegation section or society:

Texas Medical Association

Akshara Malla

RE: Enabling Methadone Treatment of Opioid Use Disorder in Prima

Akshara Malla, medical student from Arizona, speaking on behalf of the Medical Student Section in SUPPORT of Resolution 202.

In the midst of our nation’s ongoing opioid crisis, this resolution asks to reduce administrative barriers to methadone clinics and increase education and awareness of these resources among primary care providers. Our MSS strongly believes that there is desperate need to immediately address the opioid crisis with measures that increase patient access to treatment and medical care, such as the actions outlined in this resolution. Our MSS directly supports the use of methadone to manage opioid use disorder, as well as other treatment modalities to combat the opioid epidemic. Thus, we support Resolution 202 and the need to take full advantage of available treatment and management options for opioid use disorder.

Our MSS thanks the Reference Committee for their diligence and consideration of Resolution 202.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Akshara Malla

Delegation section or society:

Medical Student Section

Carla Frenzel

Support for the Development and Distribution of HIPAA-Compliant Communication Technologies

RESOLVED, That our American Medical Association promote the development and use of Health Insurance Portability and Accountability Act of 1996 (HIPAA) - compliant technologies for text messaging, electronic mail and video conferencing.

Paul Westfall

RE: Support for the Development and Distribution of HIPAA-Compli

AMA Staff has identified the following policies as relevant:

Guidelines for Patient-Physician Electronic Mail and Text Messaging H-478.997

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

- (a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- (b) Inform patient about privacy issues.
- (c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
- (d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
- (e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
- (f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- (g) Request that patients put their name and patient identification number in the body of the message.
- (h) Configure automatic reply to acknowledge receipt of messages.
- (i) Send a new message to inform patient of completion of request.
- (j) Request that patients use autoreply feature to acknowledge reading clinicians message.
- (k) Develop archival and retrieval mechanisms.
- (l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
- (m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- (n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.

- (o) Explain to patients that their messages should be concise.
- (p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
- (q) Remind patients when they do not adhere to the guidelines.
- (r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

- (a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
 - (b) Terms in communication guidelines (stated above).
 - (c) Provide instructions for when and how to convert to phone calls and office visits.
 - (d) Describe security mechanisms in place.
 - (e) Hold harmless the health care institution for information loss due to technical failures.
 - (f) Waive encryption requirement, if any, at patient's insistence.
 - (g) Describe security mechanisms in place including:
 - (h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
 - (i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
 - (j) Never using patient's e-mail address in a marketing scheme.

- (k) Not sharing professional e-mail accounts with family members.
- (l) Not using unencrypted wireless communications with patient-identifiable information.
- (m) Double-checking all "To" fields prior to sending messages.
- (n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
- (o) Commit policy decisions to writing and electronic form.
- (2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.
- (3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.
- (4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.

BOT Rep. 2, A-00 Modified: CMS Rep. 4, A-01 Modified: BOT Rep. 24, A-02
Reaffirmed: CMS Rep. 4, A-12 Modified: BOT Rep. 11, A-17

Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging D-478.970

Our AMA will develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients, and members of the health care team.

Res. 227, A-16 Modified: Speakers Rep., A-18

Opinion Type:

My post is my personal opinion

Resolution 204

Carla Frenzel

Restriction on IMG Moonlighting

RESOLVED, That our American Medical Association advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight.

COREY HOWARD

RE: Restriction on IMG Moonlighting

I would support allowing those with a J-1 in Fellowship training programs to moonlight.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

COREY HOWARD

Delegation section or society:

Florida

NIRANJAN RAO

RE: Restriction on IMG Moonlighting

My name is Niranjana Rao. I am a member of the AMA Council on Medical Education and am providing this testimony on behalf of the Council. I have no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, NBME and others.

The Council on Medical Education is in support of Resolution 204 for the following reasons: The physician shortage in the future is a reality. Fellows are fully trained in ACGME-accredited programs. Allowing them to moonlight and for the ability to bill for their services will most certainly help alleviate the shortage to some extent, especially in underserved areas.

We would recommend amending the language, however, to shift the emphasis of the resolution from 1) allowing any physician with a J-1 visa the opportunity to moonlight to 2) not using J-1 status as a rationale for prohibiting moonlighting, to read as follows:

RESOLVED, That our American Medical Association advocate for changes to federal legislation to prevent prohibition of moonlighting on the basis of having a J-1 visa for physicians in fellowship training programs. (New HOD Policy)

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

NIRANJAN RAO

Delegation section or society:

Council on Medical Education

Resolution 205

Carla Frenzel

Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)

RESOLVED, That our American Medical Association support legalization of the Deferred Action for Legal Childhood Arrival (DALCA); and be it further

RESOLVED, That our AMA work with the appropriate agencies to allow DALCA children to start and finish medical school and/or residency training until these DALCA children have officially become legal.

Resolution 206

Carla Frenzel

Repealing Potential Penalties Associated with MIPS

RESOLVED, That our American Medical Association advocate to repeal all potential penalties associated with the MIPS program.

Carla Frenzel

Defense of Affirmative Action

RESOLVED, That our American Medical Association oppose legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.

Paul Westfall

RE: Defense of Affirmative Action

AMA Staff has identified the following policies as relevant:

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.

(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.

(4) Increasing the supply of minority health professionals.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.

(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.

(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.

(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917

Our AMA: (1) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (2) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (3) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.

Res. 910, I-16

Opinion Type:

My post is my personal opinion

Luis Seija

RE: Defense of Affirmative Action

Luis Seija, Delegate from Texas, speaking on behalf of the Medical Student Section in SUPPORT as the sponsors of Resolution 207.

This resolution is delineated from current policy by actively calling upon our AMA to oppose legislation that would seek to challenge an institutions's use of race-conscious admissions policies, including affirmative action. Those against such policies argue this practice grants unqualified applicants an unfair advantage or acts within a limited scope that caters specifically to underrepresented minorities.

However, the role of affirmative action in higher education has evolved over time, proving to be more nuanced and complex than its definition lets on.

It addresses situations by allowing race to be a factor, along with many others. More broadly, it also credits those who have overcome, demonstrated resilience and been successful despite circumstances. Furthermore, it encourages diversity; not just racial diversity, but diversity of thought and experience. This distinctive filter enables schools to develop a class that is reflective and consistent with ever-changing societal needs without compromising the integrity of the admissions process itself.

The MSS speaks to this methodology because we have seen first-hand the result derived from the balance of personal characteristics and academic outcomes: the creation of a dynamic student body that has subsequently enriched our education at every level. While institutions provide the quality of the education, our peers provide the quality of the experience.

For these reasons, our AMA should advocate for institutions to retain their ability to identify and extend opportunities to individuals as they see fit. Thanks for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Luis Seija

Delegation section or society:

Medical Student Section

Resolution 208

Carla Frenzel

Increasing Access to Broadband Internet to Reduce Health Disparities

RESOLVED, That our American Medical Association advocate for the expansion of broadband connectivity to all rural areas of the United States.

Jim Rohack

RE: Increasing Access to Broadband Internet to Reduce Health Dis

I am supportive of the concept with my experience of practice in rural Texas. My only concern is having the broadband connectivity be affordable not only for physicians but for patients since many elderly are on fixed incomes. Thus, amending to expansion of affordable broadband connectivity.... would help achieve that goal.

thank you.

Opinion Type:

My post is my personal opinion

DAVID WELSH

RE: Increasing Access to Broadband Internet to Reduce Health Dis

I support the resolution and Dr Rohack's comments. As a general surgeon practicing in Rural Indiana, this can make a difference.

Opinion Type:

My post is my personal opinion

Paul Westfall

RE: Increasing Access to Broadband Internet to Reduce Health Dis

AMA Staff has identified the following policy as relevant:

Improving rural health care H-465.994.

The AMA (1) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (2) urges physicians practicing in rural areas to be actively involved in these efforts, and (3) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.

Sub. Res. 72, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CLRPD Rep. 1, A-08
Reaffirmed: CEJA Rep. 06, A-18

Opinion Type:

My post is my personal opinion

Resolution 209

Carla Frenzel

Sexual Assault Education and Prevention in Public Schools

RESOLVED, That our American Medical Association support state legislation mandating that public middle and high school health education programs include age appropriate information on sexual assault education and prevention, including but not limited to topics of consent and sexual bullying.

DAVID WELSH

RE: Sexual Assault Education and Prevention in Public Schools

I support the resolution and I urge colleagues to be involved in their local schools and volunteer on panels that can accomplish these goals.

Opinion Type:

My post is my personal opinion

Hari Iyer

RE: Sexual Assault Education and Prevention in Public Schools

Hari Iyer, Delegate from Ohio, speaking on behalf of the Medical Student Section in SUPPORT of Resolution 209. The occurrence of sexual assault in school-aged populations is a serious issue and disproportionately affects marginalized groups. It is essential that our AMA policy not only advocate for much-needed sexual assault education at the college level, but in school-aged populations as well. Our MSS supports sexual assault education as an effective intervention which prevents sexual abuse and violence, and supports education at all levels. As such, we support the action proposed by this resolution.

We appreciate the Women Physician Section's advocacy in this area. Thank you for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Hari Iyer

Delegation section or society:

Medical Student Section

DAVID WELSH

RE: Sexual Assault Education and Prevention in Public Schools

I support the resolution and I urge colleagues to be involved in their local schools and volunteer on panels that can accomplish these goals.

Opinion Type:

My post is my personal opinion

Hari Iyer

RE: Sexual Assault Education and Prevention in Public Schools

Hari Iyer, Delegate from Ohio, speaking on behalf of the Medical Student Section in SUPPORT of Resolution 209. The occurrence of sexual assault in school-aged populations is a serious issue and disproportionately affects marginalized groups. It is essential that our AMA policy not only advocate for much-needed sexual assault education at the college level, but in school-aged populations as well. Our MSS supports sexual assault education as an effective intervention which prevents sexual abuse and violence, and supports education at all levels. As such, we support the action proposed by this resolution.

We appreciate the Women Physician Section's advocacy in this area. Thank you for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Hari Iyer

Delegation section or society:

Medical Student Section

Carla Frenzel

Forced Organ Harvesting for Transplantation

our American Medical Association reaffirm Ethical Opinion E-6.1.1, “Transplantation of Organs from Living Donors,”, and believes that transplant surgeons, especially those who come to the United States for training in transplant surgery, must agree to these guidelines, and that American medical and hospital institutions not be complicit in any ethical violations or conflicts of interest; and be it further

RESOLVED, That our AMA representatives to the World Medical Association request an independent, interdisciplinary (not restricted to transplant surgeons), transparent investigation into the Chinese practices of organ transplantation including (but not limited to): the source of the organs as well as the guidelines followed; and to report back on these issues as well as the status of Prisoners of Conscience as sources of transplantable organs; and be it further

RESOLVED, That our AMA call upon the U.S. Government to protect the large number of transplant tourists by implementing legislation to regulate the evolving, ethical challenges by initiating a Reciprocal Transplant Transparency Act which would blacklist countries that do not meet the same transparency and ethical standards practiced in the U.S. (such as the public listing of annual transplant numbers by every transplant center to permit scrutiny).

Resolution 211

Carla Frenzel

Eliminating Barriers to Automated External Defibrillator Use

RESOLVED, That our American Medical Association update its policy on CPR and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications; and be it further

RESOLVED That our AMA urge AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and be it further

RESOLVED That our AMA support consistent and uniform legislation across states for the legal protection of untrained personnel who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.

DAVID WELSH

RE: Eliminating Barriers to Automated External Defibrillator Use

Support resolves 1 and 3. In resolve 2, suggest the word should for can, and leave the label. The label probably is in place for liability concerns.

Opinion Type:

My post is my personal opinion

Neal Dixit

RE: Eliminating Barriers to Automated External Defibrillator Use

Neal Dixit, Delegate from Louisiana, speaking on behalf of the Medical Student Section in SUPPORT of Resolution 211.

Our MSS recognizes the lifesaving potential of AEDs. The actions proposed by this resolution will clearly raise awareness of AED locations and the ability of non-medical professionals to use them, which have an immediate, life-saving impact. We would like to note that the first Resolved clause asks for an update on AMA policy without mentioning any specific policy. After an evaluation of existing policy, our MSS believes H-130.938 is most pertinent and would suggest that this policy be amended to be consistent with the first Resolved clause.

We are in full support of this resolution, and we thank the Reference Committee for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Neal Dixit

Delegation section or society:

Medical Student Section

Resolution 212

Carla Frenzel

Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents.

DAVID WELSH

RE: Development and Implementation of Guidelines for Responsible

I support the resolution. Perhaps a tenet for the media can be an agreement not to show the attacker's face or name unless needed for investigative purposes.

Opinion Type:

My post is my personal opinion

Dayna Isaacs

RE: Development and Implementation of Guidelines for Responsible

Dayna Isaacs, Alternative Delegate from California, speaking on behalf of the Medical Student Section in strong SUPPORT as sponsors of Resolution 212.

Mass shooting are becoming more frequent and more deadly. The FBI compiled data on active shooter incidents from 2010 to 2017, and found 250 incidents with 2,217 casualties (<https://www.fbi.gov/about/partnerships/office-of-partner-engagement/acti...>). Schools are the second highest risk location for a mass shooting. Four of the five deadliest shootings in American history happened in the past five years. More than 700 people died in a mass shooting in 2017, more than triple the number in any previous year, and so far, more than 1500 people have been killed or injured in a mass shooting in 2018.

There is ever-growing academic evidence that there is a contagion effect associated with mass shootings, with especially increased risk of copycat behavior after high profile media reporting on an incident (<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0117259>, <https://www.ncbi.nlm.nih.gov/pubmed/28726336>). Anecdotally, nationally reported incidents such as the Parkland shooting have inspired hundreds of copycat threats in the weeks that follow. Many discussions have followed about the media's role in preventing future mass shootings, but no concrete action has been taken (<https://www.wsj.com/articles/how-not-to-cover-mass-shootings-1510939088>).

A similar contagion effect has been observed around media reporting of suicide, and as a result, guidelines have been proposed and followed to reduce the incidence of suicidal behavior after a reported incident (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1732435/pdf/v057p00238.pdf>, <https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide>). Our AMA has recognized gun violence as a public health crisis, and we should take every action to prevent future mass shootings from occurring. This resolution asks the AMA to work with the most relevant stakeholders and establish guidelines that will take a step toward ameliorating the crisis of gun violence in the United States.

Thousands too many have died as a result of mass shootings, and we must take action now to prevent future loss of life to these tragedies.

Our MSS thanks the Reference Committee for their diligence and consideration of Resolution 212.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Dayna Isaacs, MPH

Delegation section or society:

AMA-MSS

Resolution 213

Carla Frenzel

Increasing Firearm Safety to Prevent Accidental Child Deaths

RESOLVED, That our American Medical Association advocate for enactment of Child Access Prevention laws in all 50 states or as federal law.

Paul Westfall

RE: Increasing Firearm Safety to Prevent Accidental Child Deaths

AMA Staff has identified the following policies as relevant:

Improving rural health care H-465.994.

The AMA (1) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (2) urges physicians practicing in rural areas to be actively involved in these efforts, and (3) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.

Sub. Res. 72, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmed: CEJA Rep. 06, A-18

Opinion Type:

My post is my personal opinion

Rodriguez-Fhon

RE: Increasing Firearm Safety to Prevent Accidental Child Deaths

Enrique Rodriguez-Fhon, medical student from Michigan, speaking on behalf of the Medical Student Section in SUPPORT as sponsors of Resolution 213.

Our resolution asks that our AMA advocate for the enactment of Child Access Prevention laws in all 50 states or as federal law. Child Access Prevention laws encourage firearm owners to be conscious of how they store firearms by levying criminal sanctions if a child gains access to or uses a firearm inappropriately. Research shows that Child Access Prevention laws have reduced the number of self-inflicted firearm injuries by 64% for individuals under 18 years of age and drive an overall reduction in the rate of child death from unintentional firearm injuries when states pass a Child Access Prevention law. We believe that these laws can benefit the health of children across all 50 states. Current AMA policy, while consistent with the spirit of this resolution, does not call for enactment of these laws across the entire nation, and as such, does not meet the best evidence-based standard on interventions that address gun violence across the country. Therefore our MSS believes that this resolution provides a novel and valuable addition to existing policy and urges its adoption.

Thank you for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Enrique Rodriguez-Fhon

Delegation section or society:

Medical Student Section

Resolution 214

Carla Frenzel

A Public Health Case for Firearm Regulation

RESOLVED, That our American Medical Association support a public health approach to evidence-based firearm laws and regulations that do not conflict with the Second Amendment to the U.S. Constitution; and be it further

RESOLVED, That our AMA oppose barriers to firearm safety.

Stephen Rockower

RE: A Public Health Case for Firearm Regulation

Despite any political implications of this resolution, this seems to be a common sense approach to the problems of firearm safety and use.

Opinion Type:

My post is my personal opinion

DAVID WELSH

RE: A Public Health Case for Firearm Regulation

I support the resolution. It is very similar to the statement by the ACS.

Opinion Type:

My post is my personal opinion

Paul Westfall

RE: A Public Health Case for Firearm Regulation

AMA Staff has identified the following policies as relevant:

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Res. 1011, A-16; Reaffirmation A-18

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

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

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Sub. Res. 31, I-81 Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17)

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; and (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children.

Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18

Waiting Periods for Firearm Purchases H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that

allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18

Firearm Availability H-145.996

1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. 2. Our AMA policy is to require the licensing of owners of firearms including completion of a required safety course and registration of all firearms. 3. Our AMA supports local law enforcement in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding “concealed carry”, by supporting “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and by supporting “red-flag” laws for individuals who have demonstrated significant signs of potential violence. In supporting local law enforcement, we support as well the importance of “due process” so that decisions could be reversible by individuals petitioning in court for their rights to be restored.

Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18

Opinion Type:

My post is my personal opinion

Resolution 215

Carla Frenzel

Extending the Medical Home to Meet Families Wherever They Go

RESOLVED, That our American Medical Association develop model legislation to permit primary care physicians, who work in medical homes/primary care practices that satisfy the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition Program guidelines, and who have documented a face-to-face patient-care relationship, to provide telehealth services for the patient when the patient travels to any of the fifty states.

GERALD CALLAS

RE: Extending the Medical Home to Meet Families Wherever They Go

Resolution 215

Extending the Medical Home to Meet Families Wherever They Go

(American Academy of Pediatrics)

Although we support the medical home concept and see it as an exceptionally worth model to improve care, reduce costs, and bolster the patient-physician relationship, the Texas Delegation opposes this resolution. Both TMA and AMA policy support the concept that physicians providing diagnostic and treatment services via telehealth or telemedicine must be licensed in the state in which the patient receives those services. Professional licensure and regulation of physicians is a state function intended to protect patients.

Current AMA policy 290.008 has it exactly right: “It allows each state to ensure that medical care delivered by electronic or other means across state lines is provided in accordance with applicable state laws, rules, and regulations governing provision of medical services in that state.”

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

GERALD CALLAS

Delegation section or society:

Texas Medical Association

Carla Frenzel

Medicare Part B Competitive Acquisition Program (CAP)

RESOLVED, That our American Medical Association advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:

- (1) it must be genuinely voluntary and not penalize practices which choose not to participate;
- (2) it should provide supplemental payments to support complex care coordination and management for cancer patients, including reimbursement for costs associated with the administration of anticancer drugs such as special handling and storage for hazardous drugs; (3) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
- (4) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
- (5) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician; and
- (6) it should not be tied to negotiated discounts such as rebates to pharmacy benefit managers given in exchange for implementing utilization management policies like step therapy.

Resolution 217

Carla Frenzel

Opposition to Medicare Part B to Part D Changes

RESOLVED, That our American Medical Association advocate against Medicare changes which would recategorize Medicare Part B drugs into Part D.

Carla Frenzel

Alternatives to Tort for Medical Liability

RESOLVED, That our American Medical Association review options for alternatives to the tort system that will assure fair compensation to individuals harmed in the process of receiving medical care and separately identify and hold accountable physicians and other practitioners for dangerous or unacceptable practice as well as identify opportunities for improving systems to maximize the safety of medical care (as in New Zealand and other countries); and be it further

RESOLVED, That our AMA develop new policy which can be used for advocacy or development of model state legislation to replace the current tort system.

Paul Westfall

RE: Alternatives to Tort for Medical Liability

AMA Staff has identified the following policies as relevant:

AMA Support for State Medical Societies' Efforts to Implement MICRA-Type Legislation H-435.943

Our AMA supports state medical associations in their opposition to proposals to replace a state medical liability system with a no-fault liability or Patient Compensation System, unless those proposals are consistent with AMA policy.

BOT Rep. 02, I-16

Tort Liability Reform H-435.993

Our AMA:

(1) supports the efforts of state medical societies to form coalitions supporting **tort reform** in each state and representing the numerous interests adversely affected by present escalating tort liability costs; and

(2) believes these coalitions should address such issues as reform of laws governing product and professional liability, and development of appropriate public education programs regarding the impact and cost to consumers of present liability laws.

Sub. Res. 6, A-84, Reaffirmed by CLRPD Rep. 3 - I-94, Reaffirmation A-00, Reaffirmation I-08, Reaffirmed: BOT Rep. 09, A-18

Federal Medical Liability Reform H-435.978

Our AMA:

(1) supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of \$250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages;

(2) reaffirms its support for the additional reforms identified in Report L (A-89) as appropriate for a federal reform vehicle. These are: (a) a certificate of merit requirement as a prelude to filing medical liability cases; and (b) basic medical expert witness criteria;

(3) supports for any federal initiative incorporating provisions of this type would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. Federal preemptive legislation that endangers state-based reform will be actively opposed. Federal initiatives incorporating extended or ill-advised regulation of the practice of medicine also will not be supported. Effective medical liability reform, based on the

California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.

BOT Rep. S, I-89, BOT Rep. I-93-53, Reaffirmed: BOT Rep. 8, I-98, Reaffirmation A-00, Reaffirmation I-03, Reaffirmed: Sub. Res. 910, I-03, Reaffirmed: Res. 206, I-09, Reaffirmation A-10, Reaffirmed: Sub. Res. 222, I-10, Reaffirmed: Res. 206, A-11, Reaffirmed in lieu of Res. 205, I-11, Reaffirmed in lieu of first resolve of Res. 214, I-15

Health System and Litigation Reform D-435.974

Our AMA will:

(1) press vigorously and creatively for inclusion of effective medical litigation reforms as part of the comprehensive federal health system/insurance reform debate now underway in Washington, DC; and

(2) consider and, as necessary, negotiate with federal policymakers on a wide range of litigation reform policy options to gain inclusion of a remedy in the health system reform package. These options might include traditional tort reforms, recovery limitations similar to those of the Veterans Administration (VA) system, demonstration/pilot programs on alternate dispute resolution systems such as the VA model and health courts, and/or other effective options to preserve patient access to care.

Res. 209, A-09, Reaffirmed: Sub. Res. 222, I-10

Liability Reform D-435.992

Our AMA:

(1) in concert with a coalition for civil liability reform, shall develop a broad-based and sustained grassroots member mobilization campaign to communicate its call for immediate legislative relief from the current tort system to our congressional representatives and senators;

(2) will work for passage of significant legislation in both houses of the US Congress on liability reform in this congressional year; and

(3) will work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process.

Sub. Res. 215, A-02, Reaffirmation I-03, Appended: Sub. Res. 910, I-03, Modified: BOT Rep. 28, A-13

Opinion Type:

My post is my personal opinion

GERALD CALLAS

RE: Alternatives to Tort for Medical Liability

Resolution 218

Alternatives to Tort for Medical Liability

(Colorado)

Separating patient compensation from physician accountability in our medical liability system is an intriguing concept, but enacting such a system would threaten the stability we have seen in Texas and other states that have enacted strong liability reforms. Since the passage of our medical liability reforms in 2003, Texas has seen growth in the physician workforce that far exceeded our state's explosive population increase; we have seen a significant reduction in the filing of frivolous professional liability claims; and we have seen physicians return to practicing in what had been high-risk areas of the state and to treating high-risk patients. Texas' reforms are based on California's MICRA model, which AMA policy 435.968 correctly states "is integral to health system reform."

The Texas Delegation would oppose this resolution without the addition of language that protects states' existing, successful medical liability reforms.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

GERALD CALLAS

Delegation section or society:

Texas Medical Association

Resolution 219

Carla Frenzel

Promotion and Education of Breastfeeding

RESOLVED, That our American Medical Association encourage the federal government to legislate appropriate disclosures of the health benefits or limitations of synthetic infant formulas, develop a breast feeding awareness education program, ensure that our representatives to global meetings comport themselves in an unbiased manner that better represents a compromise of all views of this particular issue and promote development of an affordable and more equivalent substitute for breast milk for women who absolutely are unable to nurse; and be it further

RESOLVED, That our AMA and all state medical associations support legislation for workplace accommodation for nursing mothers in those states that do not already have such laws.

Paul Westfall

RE: Promotion and Education of Breastfeeding

AMA Staff has identified the following policies as relevant:

AMA Support for Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping;

mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding

mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

Opinion Type:

My post is my personal opinion

Resolution 220

Carla Frenzel

Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement

RESOLVED, That our American Medical Association support legislation and federal funding for evidence-based training programs aimed at educating corrections officers in effectively interacting with mentally ill populations in federal prisons.

DAVID WELSH

RE: Supporting Mental Health Training Programs for Corrections O

I support this resolution. This is important.

Opinion Type:

My post is my personal opinion

Akshara Malla

RE: Supporting Mental Health Training Programs for Corrections O

Akshara Malla, medical student from Arizona, speaking in SUPPORT of Resolution 220 with an amendment. This resolution is targeted towards educating law enforcement, especially correctional officers, on how to interact with mentally ill individuals. Our MSS supports reducing incarceration rates of those with psychiatric illnesses and implementing more programs such as Crisis Intervention Team trainings that improve the law enforcement's responses to the mentally ill. Similarly, our AMA addresses the implementation of Crisis Intervention Team trainings and federal funding of these programs. Resolution 220 expands upon existing MSS and AMA policy to ask for broader support of evidence-based mental health programs for correctional officers that will reduce potential violence or conflict.

Of note, we would like to emphasize that a majority of prisoners in the U.S. criminal justice system are held in state prisons. The Bureau of Justice Statistics reported that federal prisons held 189,192 prisoners whereas state prisons held 1.32 million prisoners in 2016. Therefore, the MSS would suggest expanding the Resolved clause to include state prisons in addition to federal prisons to expand the reach and effectiveness of this resolution.

We thank the Reference Committee for their diligence and consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Akshara Malla

Delegation section or society:

Medical Student Section

Carla Frenzel

Regulatory Relief from Burdensome CMS "HPI" EHR Requirements

RESOLVED, That our American Medical Association advocate for regulatory relief from the burdensome Centers for Medicare and Medicaid Services (CMS) History of Present Illness (HPI) requirements arbitrarily equating “keystroking” in an electronic health record (EHR) with validation of the fact that a face to face encounter has been performed by the physician/NPP; and be it further

RESOLVED, That our AMA advocate for the acceptance of the physician's electronic signature as substantiation and verification that the HPI was reviewed and appropriate additional information was obtained and recorded whomever "keystroked" this information.

Paul Westfall

RE: Regulatory Relief from Burdensome CMS "HPI" EHR Requirements

AMA Staff has identified the following policies as relevant:

Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record H-225.965

The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.

BOT Rep. 58, A-96 Reaffirmed: CLRPD Rep. 2, A-06 Modified: CMS Rep. 01, A-16

Hospital Admission Histories and Physicals H-215.995

Our AMA believes that the best interests of hospitalized patients are served when admission history and physical exams are performed by a physician, recognizing that portions of the histories and physical exams may be delegated by the physician to others whose credentials are accepted by the medical staff.

I-81 Reaffirmed: CLRPD Rep. F, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CMS Rep. 7, A-11

Face-to-Face Encounter Rule D-330.914

1. Our AMA will: (A) work with the Centers for Medicare & Medicaid Services (CMS) and appropriate national medical specialty societies to ensure that physicians understand the alternative means of compliance with and payment policies associated with Medicare's face-to-face encounter policies, including those required for home health, hospice and durable medical equipment; (B) work with CMS to continue to educate home health agencies on the face-to-face documentation required as part of the certification of eligibility for Medicare home health services to ensure that the certification process is streamlined and minimizes paperwork burdens for practicing physicians; and (C) continue to monitor legislative and regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians.

2, Our AMA will work with CMS to enable the use of HIPAA-compliant telemedicine and video monitoring services to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services.

CMS Rep. 3, I-12 Appended: Res. 120, A-14 Reaffirmed in lieu of: Res. 109, A-17

Opinion Type:

My post is my personal opinion

Carla Frenzel

Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS

RESOLVED, That our American Medical Association work to establish regulation and/or legislation requiring that all quality measure data be collected in summary format only with no personally identified information included.

Paul Westfall

RE: Patient Privacy Invasion by the Submission of Fully Identifi

AMA Staff has identified the following policies as relevant:

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the

minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

BOT Rep. 9, A-98 Reaffirmation I-98 Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99 Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01 Reaffirmed: BOT Rep. 19, I-01 Appended: Res. 524, A-02 Reaffirmed: Sub. Res. 206, A-04 Reaffirmed: BOT Rep. 24, I-04 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: CEJA Rep. 6, A-11 Reaffirmed in lieu of Res. 705, A-12 Reaffirmed: BOT Rep. 17, A-13 Modified: Res. 2, I-14 Reaffirmation: A-17 Modified: BOT Rep. 16, A-18 Appended: Res. 232, A-18

Medical Information and Its Uses H-406.987

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems,

physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided.

Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.

BOT Rep. 6, A-15

Opinion Type:

My post is my personal opinion

Carla Frenzel

Permanent Reauthorization of the State Children's Health Insurance Program

RESOLVED, That our American Medical Association amend policy H-290.971, "Expanding Enrollment for the State Children's Health Insurance Program (SCHIP)," by addition and deletion to read as follows:

Our AMA continues to support:

- a. health insurance coverage of all children as a strategic priority;
- b. efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms;
- c. the permanent reauthorization of SCHIP ~~in 2007~~; and
- d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for SCHIP eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage; and be it further

RESOLVED, That our American Medical Association amend policy D-290.982, "State Children's Health Insurance Program Reauthorization (SCHIP)," by addition and deletion to read as follows:

- 1. Our AMA strongly supports the permanent reauthorization of the State Children's Health Insurance Program ~~reauthorization~~ and will lobby toward this end.
- 2. Our AMA will lobby Congress to:
 - a. provide performance-based financial assistance for new coverage costs with expanded coverage of uninsured children through SCHIP through an enhanced federal match;

- b. allow states to use SCHIP funds to augment employer-based coverage;
 - c. allow states to explicitly use SCHIP funding to cover eligible pregnant women;
 - d. allow states the flexibility to cover all eligible children residing in the United States and pregnant women through the SCHIP program without a mandatory waiting period;
 - e. provide \$60 billion in additional funding for SCHIP to ensure adequate funding of the SCHIP program and incentivize states to expand coverage to qualified children, and support incentives for physicians to participate; and
 - f. ensure predictable funding of SCHIP in the future.
3. Our AMA will urge Congress to provide targeted funding for SCHIP enrollment outreach; and be it further

RESOLVED, That our AMA actively lobby the United States Congress for a permanent reauthorization of the Children's Health Insurance Program.

Paul Westfall

RE: Permanent Reauthorization of the State Children's Health I

AMA Staff has identified the following policies as relevant:

Expanding Enrollment for the State Children's Health Insurance Program (SCHIP) H-290.971

Our AMA continues to support:

- a. health insurance coverage of all children as a strategic priority;
- b. efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program ((SCHIP)) and Medicaid through improved and streamlined enrollment mechanisms;

- c. the reauthorization of (SCHIP) in 2007; and
- d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for (SCHIP) eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage.

Res. 118, A-07 CMS Rep. 1, A-07 Reaffirmation A-14

State Children's Health Insurance Program Reauthorization (SCHIP) D-290.982

1. Our AMA strongly supports the State Children's Health Insurance Program reauthorization and will lobby toward this end.
2. Our AMA will lobby Congress to:
 - a. provide performance-based financial assistance for new coverage costs with expanded coverage of uninsured children through (SCHIP) through an enhanced federal match;
 - b. allow states to use (SCHIP) funds to augment employer-based coverage;
 - c. allow states to explicitly use (SCHIP) funding to cover eligible pregnant women;
 - d. allow states the flexibility to cover all eligible children residing in the United States and pregnant women through the (SCHIP) program without a mandatory waiting period;
 - e. provide \$60 billion in additional funding for (SCHIP) to ensure adequate funding of the (SCHIP) program and incentivize states to expand coverage to qualified children, and support incentives for physicians to participate; and
 - f. ensure predictable funding of (SCHIP) in the future.
3. Our AMA will urge Congress to provide targeted funding for (SCHIP) enrollment outreach.

Res. 117, A-07 Res. 118, A-07 Res. 119, A-07 Reaffirmation A-14

Opinion Type:

My post is my personal opinion

Carla Frenzel

Fairness in the Centers for Medicare & Medicaid Services Authorized Quality Improvement Organization's (QIO) Medical Care Review

RESOLVED, That our American Medical Association seek by regulation and/or legislation to amend the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict; and be it further

RESOLVED, That our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise; and be it further

RESOLVED, That our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed.

Paul Westfall

RE: Fairness in the Centers for Medicare & Medicaid Services Aut

AMA Staff has identified the following policies as relevant:

Reduced Physician Role in Governance of Federally Contracted Quality Improvement Organizations H-375.963

Our AMA supports the concept of improving diversity of representation on the governing bodies of Quality Improvement Organizations via the inclusion of non-physician professionals and consumers, but expresses deep concern and will forcefully advocate against any guidelines that would seek to link federal contracting with Quality Improvement Organizations with having the governing bodies of these

organizations comprised of a majority of non-physicians, as being antithetical to the fundamental principles of physician peer review and evidence based quality improvement.

Res. 137, A-07 Reaffirmed: CMS Rep. 01, A-17

Quality Improvement Organization Program Status H-340.900

Our AMA urges implementation of a Medicare beneficiary complaint process under the Medicare Quality Improvement Organization Program that meets the information needs of patients offers appropriate due process for physicians, and maintains confidentiality of review findings.

CMS Rep. 1, A-97 Reaffirmation A-01 Modified: CMS Rep. 7, A-11

Quality Improvement Organization Program Status H-340.901

Our AMA strongly urges CMS to require that Medicare Quality Improvement Organizations (QIOs) adhere to the following principles:

- (1) physicians should be provided with the fundamental principles of fairness and due process throughout QIO proceedings;
- (2) all appeal mechanisms available to physicians should be exhausted before QIOs disclose their decisions to beneficiaries;
- (3) the language used in QIO correspondence with beneficiaries should be properly worded to ensure that the patient/physician relationship is not jeopardized; and
- (4) QIOs should be required to receive affirmative physician consent before patients are notified of QIO review determinations.

CMS Rep. 7, I-96 Reaffirmed: CMS Rep. 16, I-98 Reaffirmation A-01 Reaffirmed: CMS Rep. 7, I-01 Modified: CMS Rep. 7, A-11

Quality Improvement Organization Program Status H-340.910

Our AMA will: (1) monitor the implementation of the QIO Statement of Work and continue to work with CMS to direct the QIO program in an educational, nonpunitive manner consistent with AMA policy, including: (a) requiring QIOs to utilize specialty-specific physician reviewers to make all final determinations of appropriateness and quality of care; and (b) requiring QIOs to make available to physicians under review the identities and credentials of physician reviewers. (2) The AMA will monitor the implementation of the QIO quality review and documentation review processes and continue to work with CMS to refine these processes so that they are implemented in an educational, nonpunitive manner.

CMS Rep. H, I-92 Amended and Reaffirmed: CMS Rep. 16, I-98 Modified and Reaffirmed: CMS Rep. 4, A-08 Reaffirmed: CMS Rep. 01, A-18

Quality Improvement Organization Physician Advisory Confidentiality H-340.928

The AMA petitions third party payers and CMS (1) to require QIOs and carriers to publish and forward annually to the quality assurance chairman and the chief of staff of all hospitals under their jurisdictions as well as all state medical associations, the names of physician reviewers, their credentials, and their specialties, and (2) to require that the physician reviewers reveal their identity by signing the letter submitted to a physician placed under review.

Sub. Res. 200, A-91 Reaffirmation A-99 Modified and Reaffirmed: CMS Rep. 5, A-09

Publication in Federal Register of Proposed Changes in QIO Review Process or Procedures H-340.917

Our AMA strongly urges CMS to publish in the Federal Register for review and comment any significant proposed changes in the quality improvement organization (QIO) process or procedures which would affect physician practice patterns and/or the delivery of medical care.

Sub. Res. 710, I-91 Reaffirmed: Sunset Report, I-01 Modified: CMS Rep. 7, A-11

Additionally, AMA submitted to CMS a letter in October advocating for similar due process procedures for physicians and patients, allowing for physician-to-physician conversations at the second level of review, notifying physicians when a peer reviewer does not have similar expertise or specialty as the physician subject to the QIO process, and to disclose the number of peer reviews performed by reviewers without the same expertise.

Opinion Type:

My post is my personal opinion

Resolution 225

Carla Frenzel

“Surprise” Out of Network Bills

RESOLVED, That our American Medical Association advocate that any federal legislation on “surprise” out of network medical bills be consistent with AMA Policy H-285.904, “Out-of-Network Care,” and apply to ERISA plans not subject to state regulation; and be it further

RESOLVED, That our AMA advocate that such federal legislation protect state laws that do not limit surprise out of network medical bills to a percentage of Medicare or health insurance fee schedules.

Paul Westfall

RE: “Surprise” Out of Network Bills

AMA Staff has identified the following policies as relevant:

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Mediation should be permitted in those instances where a physicians unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

Citation: Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18

Opinion Type:

My post is my personal opinion

GERALD CALLAS

RE: “Surprise” Out of Network Bills

Resolution 225

“Surprise” Out of Network Bills

(New York)

Defending physicians’ right to be paid for the services we provide and protecting our patients from surprise medical bills are important parts of a nationwide problem driven largely by insurance companies’ business practices. These include narrow networks, low-ball contract offers, limited benefits and coverage, and arbitrary allowable amounts. As this resolution points out, federal legislation could reach ERISA plans that are not subject to state regulation. The Texas Delegation, however, is very concerned that this resolution would tie such federal legislation to AMA policy 285.904, especially Section G of that policy, which states in part, “Minimum coverage standards should pay OON providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database.” It is statistically obvious that as more and more payments are made based on this benchmark, what is intended to be a floor protecting the low end of physician payments will rapidly become a ceiling limiting those payments.

Over the past several sessions of the Texas Legislature, we have successfully fought off attempts to ban physician balance billing with an alternative that has proven to be effective and politically viable. Our state law, which has evolved over the past six years, turns to mediation among the patient, the insurance company, and the physician or provider. It applies to bills of \$500 or more (after copayments, deductibles, and coinsurance) from physicians and others who provide out-of-network services at in-network hospitals, ambulatory surgical centers, birthing centers, and freestanding emergency care facilities. It also covers claims for out-of-network emergency care, with the same \$500 threshold. We have seen utilization of

the mediation process grow from 14 requests in 2010, to 1,677 in 2016. More than 90 percent of the billing disputes that go to mediation are resolved in the initial informal conference call.

The Texas Delegation cannot support Resolution 225 as long as it hinges on AMA policy 285.904. We opposed the language in Section G of that policy when it was enacted by this House and would recommend that it be deleted or amended significantly. We also would recommend that Section H of that policy be replaced with this language: “Mediation should be available to patients for bills for all out-of-network services that exceed a specific threshold after copayments, deductibles, and coinsurance.” (Note that Section H currently reads: “Mediation should be permitted in those instances where a physician’s unique background or skills are not accounted for within a minimum coverage standard.”)

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

GERALD CALLAS

Delegation section or society:

Texas Medical Association

ANN STROINK

RE: “Surprise” Out of Network Bills

Position Support:

The American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) fully support Resolution 225, as well as the existing AMA policy Out-of-Network Care H-285.904 on which it is based. We believe, however, it could be strengthened, and we urge the reference committee to consider the following:

1. While it may be the intent to create legislation to deal with all out of network care, there is clearly a difference between providing an elective service as an out of network provider in or out of an in-network facility. Among other things, there is ample time for transparency and even negotiation. Emergency care, even if protected by prudent layperson standards, is a wholly different circumstance with far-reaching implications for both patient and provider. It also bears the burden of EMTALA regulations. Consequently, some states have excluded emergency care from their “surprise” billing laws. If emergency care is to be included in any such legislation, it must have more stringent protections.

However, whatever federal standard is adopted, out-of-network payments must not be based on some percentage of Medicare rates. Nor should they be based on rates determined by the insurance company. Additionally, participating provider contractual rates are not an appropriate benchmark for determining out-of-network payment. The AANS and CNS recommend basing out-of-network payments on provably reasonable physician charges for the same service in the same geographic area is vastly superior to any methodology based on a contrived Medicare rate or a rate completely under the control of the insurance company. The FAIR Health database is an example of a database of physician charges that is geographically specific, completely transparent, and independent of the control of either payers or providers. Utilizing the 80th percentile of the FAIR Health database to determine the minimum benefit standard would exclude the highest outlier physician charges from consideration and ensure that out-of-network payment is reflective of truly reasonable charges. Implementation of such a system would substantially decrease, if not eliminate the balance billing while simultaneously creating an incentive for commercial payers to increase their network.

1. The AANS and CNS also believe that it is important that our AMA, and where appropriate state medical and national specialty societies, begin a public education campaign to educate consumers about “surprise” billing, including that it is a situation that is occurring because of gaps in insurance coverages and narrow networks. Consumers need to fully understand that the payors, rather than patients and physicians, that should be held accountable.

Resolution 226

Carla Frenzel

Support for Interoperability of Clinical Data

RESOLVED, That our American Medical Association review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.

Mark Bair

RE: Support for Interoperability of Clinical Data

As a delegation in Utah I fully support this resolution. Below is a link for the PDF file for the document referred to in the resolution. You can copy and paste from my comment to get a PDF file for download for your own review. This is a long and complicated document with many good recommendations. As a delegation we are amenable to a referral for study and report back to the HOD as needed. We may also be able to alter the language to "study" instead of making a referral for study and report back. Thank you for considering our resolution.

<https://www.thieme-connect.com/products/ejournals/pdf/10.1055/s-0038-163...>

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Mark Bair

Delegation section or society:

Utah Medical Association

DAVID WELSH

RE: Support for Interoperability of Clinical Data

Support study and report back.

Opinion Type:

My post is my personal opinion

Paul Westfall

RE: Support for Interoperability of Clinical Data

AMA Staff has identified the following policies as relevant:

EHR Interoperability D-478.972

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; (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; (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care; and (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that

prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data.

Sub. Res. 212, I-15 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: Res. 221, I-16 Reaffirmed in lieu of: Res. 243, A-17 Reaffirmed: CMS Rep. 10, A-17 Appended: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Appended: Res. 202, A-18

Information Technology Standards and Costs D-478.996

1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.

Res. 717, A-04 Reaffirmation, A-05 Appended: Sub. Res. 707, A-06 Reaffirmation A-07 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation I-08 Reaffirmation I-09 Reaffirmation A-10 Reaffirmation I-10 Reaffirmed: Res. 205, A-11 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed in lieu of Res. 724, A-13 Reaffirmation I-13 Reaffirmation

A-14 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 204, I-17 Reaffirmation: I-17 Reaffirmed: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18

Principles for Hospital Sponsored Electronic Health Records D-478.973

1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

BOT Rep. 1, I-15 Reaffirmed: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18

Health Information Technology Principles H-478.981

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;

5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of “Information Blocking.”

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

BOT Rep. 19, A-18

Opinion Type:

My post is my personal opinion

1. The rollout of state legislation on “surprise” billing has been instructive. If federal legislation is passed, then our AMA must be prepared to collect data and intervene on the part of physicians. Bad behavior by payors as well as a lack of regulatory compliance and enforcement is to be expected. This includes potential noncompliance and failure to enforce network adequacy standards, stipulated payment schedules, and dispute resolution processes.
1. There are potential improvements to existing policy that could be implemented with a federal law. One would be adding assignment of payments made to physicians in out of network situations. That would clearly help keep patients out of the anxiety-provoking loop of billing and payment collection. A second improvement would be to have payors collect deductibles from patients, rather than doctors or hospitals, in the setting of out of network care. This would be appropriate given the insurers are the contracting party, and there is growing concern over the practice of selling unaffordable high deductible coverage.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

ANN STROINK

Delegation section or society:

Neurosurgery Delegation

Resolution 227

Carla Frenzel

CMS Proposal to Consolidate Evaluation and Management Services

RESOLVED, That our American Medical Association actively seek and support congressional action before January 1, 2019 that would prevent implementation of changes to consolidate evaluation and management services as put forward in the CY 2019 Medicare physician fee schedule proposed rule if CMS in the final rule moves forward with the consolidation of evaluation and management services.

GERALD CALLAS

RE: CMS Proposal to Consolidate Evaluation and Management Service

Resolution 227

CMS Proposal to Consolidate Evaluation and Management Services

(Numerous specialty societies, Kentucky, and Georgia)

The Texas Delegation strongly supports Resolution 227. Texas submitted official comments to the Centers for Medicare & Medicaid Services (CMS) opposing the plan to consolidate payment for E/M services, and we signed on to joint comment letters from our AMA and from the Coalition of State Medical Societies. We also wrote to U.S. Reps. Kevin Brady, chair of the House Ways and Means Committee, and Michael Burgess, MD, chair of the House Health Subcommittee, both from Texas, asking them to hold hearings to “stop CMS from enacting lasting and serious damage to the Medicare program.”

CMS likely will publish the final rule sometime in the week preceding this House of Delegates meeting. Should the administration retain the proposed E/M consolidation in that final rule, it is imperative that our AMA seek congressional action before the expected Jan. 1, 2019, effective date.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

GERALD CALLAS

Delegation section or society:

Texas Medical Association

Patti Wargo

Medication Assisted Treatment

RESOLVED, That our American Medical Association advocate for all insurance plans (public and private payers) to provide coverage for medication assisted treatment of opioid use disorder by all qualified physicians. (New HOD Policy)

Paul Westfall

RE: Medication Assisted Treatment

Workforce and Coverage for Pain Management H-185.931

1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.
2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.
3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
- 4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.**

5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process.

6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable.

CMS/CSAPH Rep. 1, A-15 Reaffirmed: BOT Rep. 5, I-15 Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16 Modified: BOT Rep. 38, A-18

Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944

Our AMA opposes federal, state, third-party and other laws, policies, rules and procedures, including those imposed by Pharmacy Benefit Managers working for Medicaid, Medicare, TriCare, and commercial health plans, that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care.

Res. 710, A-13

Promotion of Better Pain Care D-160.981

1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need

for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.

2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.

3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages.

4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.

5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.

Res. 321, A-08 Appended: Res. 522, A-10 Reaffirmed in lieu of Res. 518, A-12
Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16

Opinion Type:

My post is my personal opinion

Carla Frenzel

Addressing Surgery Performed by Optometrists

RESOLVED, That our American Medical Association support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.988, "Laser Surgery"; and be it further

RESOLVED, That our AMA encourage state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.988, "Laser Surgery".

Carla Frenzel

Nonprofit Hospitals and Network Health Systems

RESOLVED, That our American Medical Association lobby federal legislators, the Internal Revenue Service, and/or other appropriate federal officials to investigate and review whether non-profit hospitals and other applicable health systems are meeting the provisions of the Internal Revenue Code relating to their tax-exempt status when they restrict or otherwise limit medical staff privileges or maintain closed medical staffs, and take appropriate action to ensure that non-profit hospitals and other applicable health systems continue to meet charitable purposes as required under applicable sections of the Internal Revenue Code.

Resolution 231

Carla Frenzel

Reducing the Regulatory Burden in Health Care

RESOLVED, That our American Medical Association work to support the repeal of the Merit-Based Incentive Payment System (MIPS); and be it further

RESOLVED, That upon repeal of MIPS, our AMA oppose any federal efforts to implement any pay-for-performance programs unless such programs add no significant regulatory or paperwork burdens to the practice of medicine and have been shown, by evidence-based research, to improve the quality of care for those served.