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Subject: Increased Use of Body-Worn Cameras by Law Enforcement Officers (Resolution 208-I-17)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B (Francis P. MacMillan, Jr., MD, Chair)

INTRODUCTION

At the 2017 Interim Meeting, the House of Delegates referred Resolution 208-I-17, “Increased Use of Body-Worn Cameras by Law Enforcement Officers,” introduced by the Medical Student Section, which asked:

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

The reference committee heard testimony largely in support of referral. Testimony emphasized the use of body-worn cameras by law enforcement officers was a matter of public health and directly related to existing American Medical Association (AMA) policy concerning the health of minorities. Others expressed concern that the issues being raised were outside of the expertise and scope of our AMA. The reference committee recommended referral in order to address all concerns raised by Resolution 218. This Board report provides background, discussion of body-worn cameras by law enforcement officers, and a recommendation.

BACKGROUND

Following a number of high-profile incidents involving deadly force used against minorities, law enforcement agencies have increasingly adopted body-worn cameras for their officers. Often affixed to the torso, body-worn cameras are small, wearable audio, video or photographic recording systems that record events in which law enforcement officers are involved. The recordings can be used to demonstrate transparency to the community, to document events and to deter inappropriate, illegal or unethical behavior by both the wearer of the camera and the public.

To date, 34 states and the District of Columbia have enacted laws governing the use of body-worn cameras by law enforcement, though not all law enforcement departments utilize cameras in the same manner. For example, some permit officers to turn off the devices under certain circumstances; others do not. In addition, a 2016 survey of large police departments nationwide found that 95 percent intended to implement or had already implemented a body camera program. According to the survey, 18 percent had fully operational programs.

The cost to law enforcement entities to implement and maintain a body camera program can be costly and is an ongoing expense. Implementing a program requires an initial capital outlay to
purchase the technology and ancillary equipment; law enforcement agencies must account for continuing operational costs, such as training on use, data storage, software and staff and operational costs required for reviewing the recordings, redacting as necessary, and providing recordings to courts and the public as appropriate. In Washington, DC, for example, the city spent over $1 million outfitting 2,800 officers and expects operating costs to top $2 million per year.3

In 2015, the U.S. Department of Justice (DOJ) Bureau of Justice Assistance (BJA) awarded $22.5 million in grant assistance to state and local law enforcement departments as part of the Body-Worn Camera Pilot Implementation Program. The Consolidated Appropriations Act, 2018 appropriated $22.5 million for a competitive matching grant program for purchases of body-worn cameras for state, local and tribal law enforcement. The BJA expects to make up to 28 awards for a three-year period, to begin on October 1, 2018. State and local funding is also available for body-worn cameras.

DISCUSSION

Predicated on whether the AMA ought to support funding of body camera programs is the question of whether the AMA ought to support the expanded use of body cameras and whether the devices achieve their intended outcomes.

Policing Activity

The underlying theory in support of body-worn cameras is that both officers and members of the community will change their behaviors for the better if their actions are being recorded. Indeed, a large body of research suggests that people act differently when they believe they are being watched. In the context of law enforcement, body-worn cameras are expected to increase self-awareness and thus deter unprofessional, inappropriate and illegal behavior by officers and civilians alike. As law enforcement officers are more likely to use force against minority community members, many hope body-worn cameras will improve policing behavior toward minorities, using force only when warranted and de-escalation tactics have failed.4,5 In cases where law enforcement officers do use force, body-worn cameras offer contemporaneous evidence of the officers’ actions so that improper behavior can be disciplined. Evidence about the impact of cameras on policing activity generally, though not universally, supports this theory.

An early study conducted in the Rialto, California police department found use-of-force incidents declined 58.3 percent over a three-year period after a body camera program was implemented.6 Importantly, researchers later found that use of force rates were higher in the same Rialto, California police force despite the presence of a camera when officers were allowed discretion to turn off cameras.7 Another randomized controlled trial conducted between 2014 and 2015 in the Las Vegas Metropolitan Police Department found that officers wearing body cameras were 12.5 percent less likely to be involved in a use of force incident.8 Similar results were found in Orlando, Florida.9 In contrast, the largest randomized controlled study to date, conducted in 2015 with the Metropolitan Police Department of the District of Columbia, found no statistically significant difference in the rates of police use of force.10

Research has found mixed results about other forms of police activity. In the study conducted in Las Vegas, body camera use was not associated with a change in the number of police-community interactions, but body cameras were associated with a 6.8 percent increase in the number of citations issued and a 5.2 percent increase in the number of events that resulted in an arrest. A 2015 study conducted in Mesa, Arizona found officers wearing a camera were less likely to perform stop-and-frisks and make arrests, but were more likely to give citations and initiate encounters.11 In
Phoenix, Arizona use of body-worn cameras were associated with a 17 percent increase in arrests.\textsuperscript{12} However, other studies have found body-worn cameras are associated with slightly lower incidents of arrest.\textsuperscript{13}

**Community Relations**

Changing policing behaviors is not the only way body-worn cameras could provide benefits. Many communities and law enforcement agencies see body cameras as a valuable way to improve policing transparency and community relations. Indeed, in 2015 when DOJ grants were announced, then-US Attorney General Loretta Lynch stated that body-worn cameras hold “tremendous promise for enhancing transparency, promoting accountability, and advancing public safety for law enforcement officers and the communities they serve.”\textsuperscript{14} Body cameras are lauded as a way for the public to better understand what transpires between law enforcement officers and civilians. Officers may also view body cameras positively, as recordings demonstrate to the community the difficult and dangerous job required of them.

Few studies have taken a comprehensive look at community attitudes toward police after the introduction of body-worn cameras.\textsuperscript{15} One such study conducted by the Urban Institute found that body-worn cameras do improve community members’ satisfaction with police encounters.\textsuperscript{13} Another study found that individuals viewed officers as having greater legitimacy, professionalism and satisfaction, but did not find significant differences between citizens’ perceptions of officers depending on whether the officer was wearing a camera.\textsuperscript{16}

The evidence is clearer, however, that body-worn cameras are associated with decreased rates of complaints filed against law enforcement officers. For example, one early study found complaints against officers dropped 88 percent following implementation of a body cameras program.\textsuperscript{6} In Rialto, California, citizen complaints declined by 60 percent. In the Las Vegas Metropolitan Police, officers wearing body cameras were 14 percent less likely to be the subject of a citizen complaint.\textsuperscript{8} In Phoenix, complaints against officers who wore the cameras declined by 23 percent, compared to a 10.6 percent increase among comparison officers.\textsuperscript{12} In contrast, research in the District of Columbia found no statistically significant difference in the rates of civilian complaints.

The available evidence does not identify the underlying behavioral changes responsible for the decline in complaint rates, however. It may be that body-worn cameras have the intended effect of changing officer behavior for the better, thus reducing circumstances that warrant citizen complaints. It may be that cameras have a “civilizing” effect on members of the public as well. Some evidence also suggests that frivolous complaints are less likely to be filed when recordings are available.\textsuperscript{15}

It is important to note, however, that use of body cameras will not automatically foster greater trust between law enforcement and members of the community and should not be viewed, as one evaluation noted, as a “plug-and-play” solution.\textsuperscript{10} Notably, the Urban Institute found body-worn cameras improved community satisfaction to a lesser extent than did procedurally just practices, defined in that study as behaving fairly and acting with empathy.\textsuperscript{13}

**Privacy Considerations**

Though the use of body cameras promises greater transparency of law enforcement behavior and actions, they also present new problems, namely intrusion into the privacy of victims, witnesses and bystanders. For instance, law enforcement officers frequently enter individuals’ homes and in-home recordings would become part of the public record. Similarly, interactions and conversations
with victims and witnesses could make those individuals uncomfortable or put those individuals in
danger. Heavily policed communities – often minority communities – will be more heavily
recorded.

These privacy concerns could be addressed with policies to limit recording during such encounters
and by limiting the circumstances under which recordings are made available to the public. The
American Civil Liberties Union (ACLU) recommends use of body cameras with significant
privacy protections. Officer privacy may also be a concern. Some law enforcement unions have
opposed body-worn cameras, arguing that adoption of the technology must be negotiated as part of
the collective bargaining agreement.

This report acknowledges the significant privacy concerns raised by the ubiquitous use of body-
loaded cameras, but notes that questions about when cameras need to be turned on and off, how long
to keep footage, when recordings will be made publicly available and other policy details are
beyond the expertise of the AMA.

Nexus with the AMA’s Mission

The AMA does not have policy specifically addressing the use of body-worn cameras among law
enforcement. During the debate over Resolution 208 during the 2017 Interim Meeting, the
reference committee heard testimony questioning whether this topic is within the scope of the
AMA’s expertise. This concern is reasonable, as AMA has not historically delved into issues of
policing and significant resources would be required to bring the AMA into the public policy
debates surrounding community policing efforts. Further, while there are dozens of organizations
(the Police Executive Research Forum, Leadership Conference on Civil and Human Rights, ACLU,
etc.) that are actively engaged on this issue, it does not appear that any other major medical
associations have emerged as significant stakeholders.

Nevertheless, there is a connection between health and police activity, particularly in terms of
minority fatality rates. Research has demonstrated that minority communities are disproportionately
subject to police force. Specifically, according to an analysis of FBI statistics, African-Americans
account for 31 percent of police-involved shootings, but comprise 13 percent of the U.S.
population.4 African-American males are particularly at risk. According to another analysis,
African-American males are three times more likely to be killed by police than non-Hispanic white
males.5

Research has also shown a correlation between policing and other health outcomes. In particular, a
recent study found that police killings of unarmed African-Americans were associated with
1.7 days of poor mental health annually among African-Americans. The findings were seen
regardless of whether the individual affected had a personal relationship with the victim or whether
the incident was experienced vicariously. In addition, the numbers of police stops, coupled with the
level of invasiveness during police encounters, is associated with increased levels of stress and
anxiety.17,18 African-American men report more anxiety and post-traumatic stress disorder and
more morbidity from these psychiatric conditions than Caucasian men.5 In addition, research of
data from the New York Police Department revealed that residents in neighborhoods with higher
rates of stop-and-frisks were more likely to be in poor health, measured in terms of high blood
pressure, diabetes, asthma and self-rated health.18 Research on the correlation between health and
policing, however, remains sparse and warrants further research.
RELEVANT AMA POLICIES

Existing AMA policy does not address the use or funding of body-worn cameras. However, AMA policy does state that physical or verbal violence between law enforcement officers and the public, particularly within ethnic and racial minority communities, is a social determinant of health and supports research into the public health effects of violent interactions. (H-515.955) In addition, Policy H-350.971 “AMA Initiatives Regarding Minorities” instructs the AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health.

New policy adopted during the 2018 Annual Meeting encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies. New policy also encourage appropriate stakeholders, including law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

Additionally, Policy H-145.977 “Use of Conducted Electrical Devices by Law Enforcement Agencies” cautions against excessive use of conducted electrical devices (often called Tasers) and recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training and an accountability system for the use of conducted electrical devices. AMA policy recommends research into the health impacts of conducted electrical device use and development of a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to conducted electrical devices.

RECOMMENDATION

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.

Fiscal Note: Less than $5,000
REFERENCES

3. Austermuhle M. Almost every D.C. cop is getting a body camera. Here’s what you need to know. Available at https://wamu.org/story/15/12/15/just_about_every_dc_cop_will_soon_have_a_body_camera_heres_wha you_need_to_know/. Accessed June 27, 2018.
Subject: Exclusive State Control of Methadone Clinics (Resolution 211-I-17)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B (Francis P. MacMillan, Jr., MD, Chair)

INTRODUCTION

At the 2017 Interim Meeting, the House of Delegates referred Resolution 211-I-17, “Exclusive State Control of Methadone Clinics,” introduced by the Indiana Delegation, which asked:

That our American Medical Association support complete state control of all aspects of methadone clinic approval and operations; and, if deemed necessary, this control could be granted on a state by state basis.

Reference committee testimony generally was mixed and noted that there is likely both a state and federal role as it relates to methadone clinic approval and operations. Delegates encouraged further study, including discussion about methadone clinic reporting to state prescription drug monitoring programs (PDMP). This report reviews existing information, provides background and presents recommendations.

DISCUSSION

Your Board strongly agrees with the authors of Resolution 211-I-17 that methadone clinics provide a valuable service to patients with an opioid use disorder. Methadone maintenance therapy (MMT) for the treatment of opioid use disorder has been used for more than 40 years to help patients, having been approved in 1972 by the U.S. Food and Drug Administration (FDA) for treatment of heroin addiction. The health and safety of methadone has been studied extensively and ample evidence exists supporting its use to aid in mortality and crime reduction.1

There are more than 1,600 certified opioid treatment programs (OTPs) offering methadone in the U.S.2 According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the number of persons receiving methadone increased by 34 percent from 2006 (258,752) to 2016 (345,443).3 With respect to opioid-related mortality, deaths attributed to methadone increased rapidly from 1999 (784 deaths) to their peak in 2007 (5,518) and have steadily declined since with 3,373 methadone-related deaths in 2016, according to the Centers for Disease Control and Prevention.4 It is beyond the scope of this report to detail whether the methadone use in these deaths was for the treatment of pain, for opioid use disorder, related to illicit use or was a complicating polypharmacy factor.

The FDA, U.S. Drug Enforcement Administration (DEA), U.S. Department of Health and Human Services (HHS) and states each have a role to play in the oversight and administration of MMT.
**FDA Regulatory Authority**

Within the broad scope of FDA’s regulatory authority is the review and approval of drugs, both brand name and generic. A general overview of the FDA process can be found online: [https://www.fda.gov/Drugs/DevelopmentApprovalProcess/default.htm#FDA](https://www.fda.gov/Drugs/DevelopmentApprovalProcess/default.htm#FDA). With respect to methadone, the FDA approved a New Drug Application for methadone in 1947. There were intervening actions, but for the purposes of this report, the FDA issued regulations for methadone Investigational New Drugs in 1971; proposed new regulations in April 1972; and issued final regulations in December 1972. 

**DEA Regulatory Authority**

DEA authority with respect to methadone focuses on the medication’s classification as a Schedule II controlled substance. Included within DEA’s responsibilities is the “enforcement of the provisions of the Controlled Substances Act as they pertain to the manufacture, distribution, and dispensing of legally produced controlled substances.” As a controlled substance, methadone falls within this scope.

**HHS Regulatory Authority**

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), a division within HHS, has broad regulatory authority concerning MMT and opioid treatment programs (OTP). This includes the authority to certify OTPs, which is defined as “a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 USC 823(g)(1).”

Regulations concerning OTPs, where patients receive MMT (and other medications and treatments), provide guidance for numerous issues. These issues include accreditation of opioid treatment programs, certification and treatment standards for OTPs, procedures for review of suspension or proposed revocation of OTP certification, and of adverse action regarding withdrawal of approval of an accreditation body, and more.

Specifically related to methadone, 42 CFR Part 8 provides that “methadone shall be administered or dispensed only in oral form and shall be formulated in such a way as to reduce its potential for parenteral abuse.” It also provides that:

For each new patient enrolled in a program, the initial dose of methadone shall not exceed 30 milligrams and the total dose for the first day shall not exceed 40 milligrams, unless the program physician documents in the patient’s record that 40 milligrams did not suppress opioid abstinence symptoms.

There also are requirements for frequency of patients receiving toxicology tests, treatment of pregnant patients, requirements for take-home doses of methadone, and more.

**State Authority**

There are numerous areas where state regulatory authority and linkages with federal oversight exist regarding OTPs. One prominent area concerns who shall serve as the medical director of the OTP. Federal regulations require that the medical director must be “a physician licensed to practice medicine in the jurisdiction in which the [OTP] is located.” State licensure is squarely within the exclusive control of state licensing boards. Federal regulations also require that there are adequate
staffing requirements, employment qualifications and other personnel-related issues. These are
going to the control of the state. And while it is complicated and beyond the scope of this report,
states also have a certain amount of leeway in determining zoning requirements for where an OTP
would be located. Notably, your Board strongly supports OTPs being treated no differently than
any other medical clinic that may seek to provide care in a community.10

SAMHSA also has recognized the clear need for OTPs to work with leaders in the community to
ensure comprehensive support services. That is, to support/encourage collaborative, multiagency
surveillance efforts to obtain timely and comprehensive data to target interventions and inform
prevention and response efforts. This includes working with the community to help determine
where an OTP is most needed; how an OTP can be integrated into the community with the least
impact on neighborhoods and traffic, for example; how to help educate the community on the
benefits of treatment for opioid use disorder so as to reduce stigma; and other areas.11

Another area of state control—which raises potential conflicts with federal law—concerns whether
OTPs should be required to report methadone dispensing information to the state PDMP. This issue
is extremely controversial. In fact, while this issue was raised by the resolution that gave rise to this
report, it also was raised in Resolution 507 from the 2018 Annual Meeting. Resolution 507-A-18
was referred for further study of a more extensive range of privacy and clinical issues relating to
PDMPs and OTPs. Given that your Board is currently deliberating on Resolution 507-A-18, and
the fact that SAMHSA has not specifically resolved the many issues associated with reporting OTP
information to state PDMPs,12 your Board believes it would be prudent to delay further comment
here so as not to cause confusion with pending research and discussions. Your Board does note,
however, that our AMA continues to urge physicians to use PDMPs to help inform their clinical
decision making. There is nothing to prevent physicians and other health care professionals in an
OTP from checking the state PDMP to ensure a patient is not receiving prescriptions for controlled
substances from other providers. Whether an OTP should report to a PDMP, however, is a matter
of federal—not state—jurisdiction.

Additional areas where states can help complement the medical care provided at OTPs include
promotion of take-home naloxone (governed by state law); education that helps remove the stigma
associated with MMT and medication assisted treatment (MAT); working toward policies that
remove health insurance and pharmacy benefit management company barriers to receiving MMT
and MAT (e.g., prior authorization, network adequacy for mental health care); prompt and accurate
overdose reporting for surveillance efforts related to prevention, treatment, and response;
identification of linkages within the community to peer counseling and other support services, to
name a few.

Furthermore, to complement and assist OTPs with the federal requirement to help an OTP identify
and prevent patients from enrolling in multiple OTPs concurrently, states can develop
communications and other tools to help OTPs (and other health care providers) identify all OTPs
doing business in a state and in surrounding areas. Federal rules already require an OTP to take
reasonable measures to do this. It seems reasonable that this would be an area where the state,
working with health insurance companies and other payers, as well as with the medical community,
would be well-advised to develop such a mapping/informational tool. This would not only allow
OTPs to more easily communicate with each other, but it would help patients identify where OTPs
exist in the state.

In Indiana, for example, the federal OTP locator maintained by SAMHSA identifies 16 OTPs
operating in the state,13 but it does not allow for multiple states to be displayed simultaneously. The
SAMHSA locator also does not allow for multiple OTPs within the state to be displayed
simultaneously. While the AMA appreciates the technical and other challenges that may be present in maintaining and keeping a current list of OTPs, creating a more robust OTP locator tool may be an area where state-based expertise and multistate partnerships can tailor solutions so that patients and physicians would be able to more easily locate and communicate with OTPs.

AMA POLICY

Relevant AMA policy provides for strong support of access to methadone. This includes MMT used in combination with behavioral and social supports, as well as support for physicians and organized medicine to provide education and training regarding treatment of substance use disorders (Policy H-95.957, “Methadone Maintenance in Private Practice;” Policy D-120.985, “Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone”). AMA policy also calls for continued funding of OTPs operating in states (Policy D-95.999, “Reduction of Medical and Public Health Consequences of Drug Abuse: Update”); and for the AMA to “advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities” (Policy D-95.968, “Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder”). AMA policy also clearly supports MAT in correctional settings and in the community in conjunction with counseling (Policy H-430.987, “Opiate Replacement Therapy Programs in Correctional Facilities”).

AMA policy also calls for continued funding of OTPs operating in states (Policy D-95.999, “Reduction of Medical and Public Health Consequences of Drug Abuse: Update”); and for the AMA to “advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities” (Policy D-95.968, “Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder”).

AMA policy also provides, in part, that “local communities or regions should exercise the responsibility for assessing their needs with respect to the type, size, scope, and location of health care facilities. State governments should ensure that needs of the underserved are being met satisfactorily without wasteful duplication” (Policy H-205.992, “Supply and Distribution of Health Care Facilities”).

RECOMMENDATIONS

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)

Fiscal Note: $2,500
REFERENCES


4 Opioid Overdose Deaths by Type of Opioid. Kaiser Family Foundation analysis of CDC data. Available at https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-type-of-opioid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D


7 42 CFR Part 8, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efe45&ty=HTML&h=L&n=pt42.1.8&r=P ART#se42.1.8_12

8 42 CFR Part 8, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efe45&ty=HTML&h=L&n=pt42.1.8&r=P ART#se42.1.8_12

9 42 CFR Part 8.12


Subject: Advocacy for Seamless Interface Between Physicians Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) (Resolution 212-A-17; BOT Report 12-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B (Francis P. MacMillan, Jr., MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 212-A-17, submitted by the American College of Legal Medicine (ACLM). The resolution asked that our AMA:

Join the American College of Legal Medicine to advocate federally-mandated interfaces between provider/dispenser electronic health record systems in the clinical, hospital and pharmacy environments and state prescription drug databases and/or prescription drug management plans;

Advocate that the cost of generating these interfaces be borne by the commercial EHR and dispensing program providers;

Advocate that the interface should include automatic query of any opioid prescription, from a provider against the state prescription drug database/prescription drug management plan (PDMP) to determine whether such a patient has received such a medication, or another Schedule II drug from any provider in the preceding ninety (90) days;

Advocate that the prescriber and the patient’s EHR-listed dispensing pharmacy should then be notified of the existence of the referenced patient in the relevant PDMP database, the substance of the previous prescription(s) (including the medication name, number dispensed and prescriber’s directions for use) in real time and prior to the patient receiving such medication;

Advocate that the electronic record management program at the pharmacy filling the relevant prescription, contemporaneously as it enters the filling of the prescription by the pharmacist, likewise be required to automatically query the state PDMP as a secondary mechanism to prevent inappropriate prescribing, forgery, duplication and/or too great a frequency of use of the involved controlled medication;

Work with ACLM and other concerned societies to urge Congress to timely enact and implement such a statutory scheme supported by a workable and concise regulatory framework, chiefly concentrating on the interfacing of all applicable electronic health record and pharmaceutical dispensing systems with every individual state’s PDMP, thereafter designating a timeframe wherein all treating providers and dispensing pharmacists would be
required to perform such queries, in concert with the routine ordering of and filling of a
controlled substance to be used in the treatment of patients;

Advocate that oversight of the appropriate prescribing of and filling of prescriptions for
controlled substances remain with the involved individual federal and state criminal law
enforcement agencies, the involved state departments of health, or similar entities and the
involved relevant state provider and/or pharmacy licensure authorities; and

Advocate that statistics be maintained and reviewed on a periodic basis by state PDMP
personnel and relayed to state departments of health or agencies similarly situated so as to
identify and possibly treat those patients identified through this screening mechanism as
potential drug abusers and/or at risk of addiction.

Board of Trustees (BOT) Report 12-A-18 summarized work that the AMA has done in support of
ensuring accurate, reliable Prescription Drug Monitoring Programs (PDMPs) that support clinical
decision-making. It also addressed many of the complexities raised in the original resolution,
including evolution of PDMPs, and their integration with electronic health records (EHRs) and
electronic prescribing of controlled substances (EPCS).

After debate, the HOD referred BOT Report 12-A-18 back for consideration. While general
support existed for the recommendations contained in the report, the HOD asked for additional
information on the evolution of PDMPs. This report, therefore, updates and expands upon the

DISCUSSION

More than 300 million queries of state PDMPs were made in 2017, more than doubling the 136
million queries in 2016, and five times the 61 million queries submitted in 2014.\(^1\) Physician
adoption of EHRs also continues to grow. The Office of the National Coordinator for Health
Information Technology maintains that nearly 90 percent of office-based physicians are using
EHRs.\(^2\)

A major goal of AMA advocacy and many others continues to be the integration of electronic
systems that can support efforts to address the opioid epidemic. To effectively support physician
and public health efforts to prevent opioid overdose deaths, the AMA has urged that electronic
systems be interoperable and integrated into medical practice workflows. As noted in BOT
Report 12-A-18, information exchanged with EHRs is not well incorporated into the physician’s
workflow. Obtaining important information, including PDMP data, often requires multiple
“clicks,” opening multiple windows, and the use of separate logins even before the physician
locates what he or she is looking for—and that situation must be repeated for each patient and
every prescription for a controlled substance. Effective PDMP and EHR integration means that the
workflow must achieve “functional interoperability,” or the ability for systems to exchange,
icorporate and display data in a meaningful and contextual manner.

The Centers for Medicare & Medicaid Services highlighted this in a recent letter to state Medicaid
directors, noting that when integration occurs, it “removes the requirement for providers to log in to
a separate system, manage a separate log in, and disrupt their workflow to query the PDMP. Single
sign-on interoperability between EHR and PDMP such that PDMP results are displayed when the
EHR indicates a controlled substance is prescribed could be supported, as an example.”\(^3\)
Many consider the ideal practice to be a “one-click” solution with PDMP data and EPCS integrated into physicians’ EHR systems. On one hand, many EHR vendors are pulled in too many directions to focus on this need. Federal regulations require vendors to develop EHRs that meet administrative requirements. To achieve the ideal for PDMP and EPCS integration, more must be done to reduce the regulatory pressure on health IT development, allowing vendors the flexibility to respond to physician and patient needs, rather than spending the bulk of their time complying with administrative demands.

Yet, there have been reports of progress of successful PDMP-EHR integration. For example, the University of North Carolina (UNC) Health Care at Chapel Hill, reported that efforts to integrate its Epic EHR with the state PDMP have been positive. A news report from July found that “[i]n the first two weeks, more than 540 UNC clinicians used the PDMP when treating some 2,950 patients, which officials said had saved physicians about 119 hours already.”

Ochsner Health System in New Orleans, Louisiana, also has used Epic to integrate the EHR with the state PDMP. Deaconess Health, which operates several hospitals in Indiana, also has made strides to integrate EHRs with the state PDMP. And there are many different options in the commercial market, although your Board notes that a Google search of effective PDMP-EHR integration efforts results in dozens of options.

In addition to growing physician use of PDMPs, interstate interoperability has expanded considerably. According to the National Association of Boards of Pharmacy, 44 states now can securely share PDMP information across state lines. The effects of expanded PDMP use on patient care are mostly unknown; physicians and other health care professionals are not the only ones interested in using the PDMP data.

As noted above, PDMP use among physicians and other health care professionals has significantly increased in recent years; however, opioid-related mortality continues to increase, driven principally by heroin, illicit fentanyl, and other synthetic derivatives. Moreover, as PDMP use increases and opioid prescribing rates decrease, it is not clear that PDMPs are making a significant impact on improving patients’ pain care. One review concluded that “[e]vidence that PDMP implementation either increases or decreases nonfatal or fatal overdoses is largely insufficient, as is evidence regarding positive associations between specific administrative features and successful programs. Some evidence showed unintended consequences. Research is needed to identify a set of “best practices” and complementary initiatives to address these consequences.”

There may also be a need for additional clarity on how PDMP data may be used by non-health care professionals, including health insurance companies, pharmacy benefit management companies (PBMs), and law enforcement. For example, earlier this year, the U.S. Department of Justice and 48 attorneys general reached an agreement to share data. According to the news release, “Drug Enforcement Agency DEA will provide the Attorneys General with that data, and the states will provide their own information, often from prescription drug monitoring programs (PDMPs) to DEA. Under the agreement, both state and federal law enforcement will have more information at their disposal to find the tell-tale signs of crime.” It is not clear what these “tell-tale signs” might be.

Progress has been considerably slower in achieving EPCS uptake, largely due to outdated regulations from the DEA. The combination of personal identification numbers (PINs), passwords, and biometrics required to meet DEA standards for “two-factor authentication” increase EPCS security but add to workflow disruptions and increase costs. DEA, EPCS requirements include onerous limits on use of biometric devices, which must comply with federal standards that set an unnecessarily high bar and prevent use of user-friendly consumer electronics already found in
physicians’ offices for two-factor authentication. The biometric fingerprint scanners found on these consumer devices, i.e., smart phone, tables, and laptop computers, are used for secure access to other sensitive information, like banking and medical records, but typically do not comport with rigid rules for EPCS.

The AMA views EPCS as important to support high-quality patient care. Physicians commonly report that they are frustrated that they can e-prescribe non-controlled substance medications but must still use written prescriptions for controlled substances. More than 70 percent of physicians are e-prescribing non-controlled drugs but only 20 percent used EPCS. One reason for this is due to the fact that not all EHR vendors understand or can satisfy EPCS requirements—state EPCS mandates have increased uptake, but implementation has been delayed due to questions about system certification, cost to providers, and patient concerns, i.e., transferring prescriptions between pharmacies. Moreover, EHR vendor processes for EPCS do not always align well with normal e-prescribing workflows—often physicians must start new computer programs and windows each time they use EPCS. Cumbersome workflows and applications that do not take physician needs into account impede EPCS uptake. Finally, although EPCS reduces prescription fraud and diversion, it is less clear how it affects valid prescriptions for opioid analgesics. For example, does the prescriber using EPCS put in a dose and duration or are numbers suggested by the EPCS system and, if so, how are these amounts derived? These are among the questions the AMA has been asking from vendors and physicians.

To help resolve other barriers, the AMA and the President’s Commission on Combating Drug Addiction and the Opioid Crisis have recommended the DEA modify EPCS regulations in order to reduce barriers to EPCS adoption. The AMA asked DEA to reexamine the scope of technology that is compliant with EPCS requirements and allow use of lower-cost, high-performing biometric devices in two-factor authentication. The AMA also believes that there must be further study to evaluate the variations in how EPCS systems handle initial dosing, i.e., are opioid doses or durations auto-populated in EPCS systems and, if so, are the amounts appropriate.

A final point is that the AMA has made clear to the DEA that its requirements for biometric devices limit user-friendly consumer electronics already found in physicians’ offices, such as fingerprint readers on laptop computers and mobile phones, from being utilized for two-factor authentication in EPCS. This and other rules contribute to cumbersome workflows and applications which are an impediment to physician EPCS uptake. Encouraging EPCS uptake and interoperability of PDMP databases and electronic health records would improve the integration of controlled substance use data into practice workflows and clinical decision-making.

The AMA also continues its efforts in support of making PDMPs better clinical tools. The use of PDMPs continues to increase in states regardless of mandates—tied mainly to quality of the PDMP as a decision-support tool in those states without mandates. Important policies that have improved PDMP workflow and data reliability include delegate access, data input by pharmacists within 24 hours, and states sharing PDMP information. PDMP usability continues to improve, but usage in rural and other areas may be affected by lack of access to broadband and other technologies. Consistent, long-term funding of state PDMPs is also a concern—most states depend on federal grants for ongoing maintenance and improvements. The AMA also continues to try and identify best practices in designing PDMPs to identify risk including: distinguishing between uncoordinated care, misuse, and “doctor shopping,” identifying opportunities for referrals to specialized care; providing reports to prescribers to better inform prescribing decisions; and conducting public health surveillance activities.
One best practice is PDMP and EHR integration, but, as previously discussed, that goal remains largely elusive. It is not clear, for example, how many PDMPs are integrated into EHRs, which makes identification of best practices challenging given the variety of EHR systems in use. Each state PDMP may require a slightly different interface to connect to an EHR. With over 600 different EHRs on the market, the number of custom EHR/PDMP interfaces required can reach into the thousands. Custom software development is time-consuming and expensive—with costs being passed on to the physician. Without PDMP and EHR integration, physicians must use multiple usernames and passwords to shuttle between different systems, often having to re-enter login information if one system times out while they are using the other one. This results in increased time to enter information, decreased satisfaction with the technology, and potentially less use of the systems.

Furthermore, the AMA notes that one dominant PDMP developer is responsible for the PDMP platforms of more than 40 states. PDMP quality and uptake has improved and it is clear that the PDMP interface is moving toward greater integration through the use of more advanced tools offered by the developer. This development, along with the growing interstate interoperability has led, anecdotally, to physicians receiving a greater number of alerts about potentially dangerous drug combinations, multiple prescriber events, and other clinical issues. Yet, these advanced tools are not without costs, and it is not clear how these tools may be affecting patient care. The PDMP interface can help identify a patient’s prescription history, but that is only one component of effectively screening a patient for a potential substance use disorder or helping understand whether a patient’s pain is being effectively managed.

Similarly, while there are some positive examples with PDMP-EHR integration, EHRs are generally not interoperable between different organizations, making coordination between primary care physicians, pain medicine physicians, addiction medicine physicians and other providers much more difficult. When PDMP and EHR integration does exist (e.g., Oregon’s EDIE), the patient, public health and cost utilization benefits are extremely positive. This integration requires time and broad, institutional support. For example, the state of Washington’s integration project with the state Health Information Exchange (HIE) began in 2012. As of August 2017, more than 90 percent of emergency departments include PDMP data in the EHR using data through the HIE. The state’s major health systems still are working to accomplish this integration.

To help resolve some of these issues, the AMA advocates for consistent and sufficient appropriations to support a state’s ability to maintain and improve its PDMP, including broad state-based grants to improve statewide HIEs and the ability to integrate HIE data into the EHR of statewide emergency departments and other providers. The AMA also would support a U.S. Government Accountability Office study on best practices for small and large physician practices on using PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying how PDMPs can distinguish uncoordinated care from misuse or “doctor shopping” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. In addition, a need exists to evaluate the variations in state-based PDMP technology and work with the health IT industry to discuss “common understanding” of how each PDMP works—providing transparency for EHR vendors to facilitate development of custom connections between their products and PDMP software. This could include funding for programs that pilot test low-cost technologies to better integrate EHRs and PDMPs as well as efforts to identify burdensome federal regulations that prevent EHRs from being designed and developed to support objective clinical decision-making.

The AMA also has been engaged in the SMART project to help EHR systems work better for physicians and patients. A key component of this effort is the development of a flexible
information infrastructure that allows for free, open development of plug and play applications (apps) to increase interoperability among health care technologies, including EHRs, in a more cost-effective way. The infrastructure development specific to PDMPs is part of both ongoing research as well as work by states working to achieve more comprehensive data integration. In addition, the Office of the National Coordinator for Health Information Technology has compiled multiple sources and pilot examples for PDMP and EHR integration. The pilot examples, not surprisingly, found that PDMPs were most helpful when they were integrated into physicians’ workflow as well as EHRs.

AMA POLICY

The AMA House of Delegates has provided strong guidance to the AMA that reflects the issues raised by the original resolution that is the subject of this report. Relevant policies include:

Policy H-120.957, “Prescription of Schedule II Medications by Fax and Electronic Data Transmission,” which “encourages the Drug Enforcement Administration to support two factor authentication that is easier to implement than the current DEA and EPCS security requirements; and because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, does not support the use of “hard copy” facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations.”

In addition, Policy H-95.928, “Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing,” provides that the AMA support multiple facets of PDMP development, including interoperability, assisting physicians and pharmacists in identifying “when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame.”

Policy D-478.972, “EHR Interoperability,” calls for the AMA to continue efforts in support of EHR interoperability standards, reducing excessive costs and generally reducing barriers to EHR adoption.

Finally, Policy D-478.994, “Health Information Technology,” broadly notes AMA support for “legislation and other appropriate initiatives that provide incentives for physicians to acquire health information technology,” which reasonably would include PDMP EPCS and EHR uptake.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 212-A-17, and 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)

Fiscal Note: Less than $500
REFERENCES

6 Additional efforts in the commercial market to better integrate PDMP use into clinical workflow and integrate with EHRs include PMP Gateway from Appriss Health (https://apprisshealth.com/solutions/pmp-gateway/), web-based apps using SMART on FHIR protocols (https://apps.smarthealthit.org/app/rxorbit-inworkflow-app), a product from Allscripts (https://allscriptsstore.cloud.prod.iapps.com/applications/id-17010/LogiCoy_PDMP), to name a few.
7 National Association Boards of Pharmacy. Available at https://nabp.pharmacy/initiatives/pmp-interconnect/
11 Appriss Health Gateway explained at https://apprisshealth.com/solutions/pmp-gateway/
15 PDMPConnect. Office of the National Coordinator for Health Information Technology. Available at https://www.healthit.gov/pdmp/PDMPConnect
REPORT OF THE BOARD OF TRUSTEES

Subject: 340B Drug Discount Program
          (Resolution 225-A-18 Resolve 3)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
             (Francis P. MacMillan, Jr., MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting of the House of Delegates (HOD), the third resolve of Resolution 225-A-18 was referred for report back at the 2018 Interim Meeting. Resolution 225-A-18, sponsored by American Society of Clinical Oncology (ASCO), asked that our American Medical Association (AMA):

(3) support discontinuing the use of the Disproportionate Share Hospital (DSH) adjustment as a determining measure for 340B program eligibility;

The reference committee heard mixed testimony on this resolve. Testimony was offered that additional research and analysis is needed to assess how to identify the DSH hospitals that should not benefit from 340B program rebates and those that should. The reference committee recommended adopting Resolves 1, 2, and 4, and referral of Resolve 3 for a report back at the 2018 Interim Meeting.

AMA POLICY

Our AMA has an extensive policy that supports increased pharmaceutical drug and biological affordability and policies to ensure patient access to medically necessary prescription medication. However, our AMA does not have specific policy concerning the 340B program other than the HOD adopted resolves of Resolution 225-A-18 (Policy H-110.985, “340B Drug Discount Program”). There is a policy related to rebates which provides that our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. (Policy H-110.987, “Pharmaceutical Cost”). Thus, there is support for rebate programs to the extent such programs benefit underinsured patients and patients living on low-incomes. Consistent with the foregoing, AMA policy provides support for the subsidization of prescription drugs for Medicare patients based on means testing (Policy H-330.902, “Subsidizing Prescription Drugs for Elderly Patients”). However, AMA policy also includes support for economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured (Policy H-125.977, “Non-Formulary Medication and the Medicare Part D Coverage Gap”).

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BACKGROUND

The 340B program, which is administered by the U.S. Department of Health and Human Services’ (HHS) Health Resources and Services Administration (HRSA), requires pharmaceutical manufacturers to sell outpatient prescription medication at a discount to covered entities. Congress established the 340B program in order to produce savings for certain safety-net health care providers by allowing them to purchase outpatient drugs at these discounted prices. The U.S. House of Representatives’ report, accompanying the original legislation, stated that these savings would “enable [participating] entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” Pharmaceutical manufacturers are required to enter into an agreement, called a pharmaceutical pricing agreement (PPA), with the HHS Secretary. Under the PPA, the manufacturer agrees to provide front-end discounts on covered outpatient prescription medication purchased by “covered entities.”

The 340B program definition of “covered entity” includes six categories of hospitals: (1) disproportionate share hospitals (DSHs); (2) children’s hospitals; (3) cancer hospitals exempt from the Medicare prospective payment system; (4) sole community hospitals; (5) rural referral centers; and (6) critical access hospitals (CAHs). In addition, to qualify hospitals must be (1) owned or operated by state or local government, (2) a public or private non-profit corporation which is formally granted governmental powers by state or local government, or (3) a private non-profit organization that has a contract with a state or local government to provide care to low-income individuals who do not qualify for Medicaid or Medicare. Also, hospitals must meet payer-mix criteria related to the Medicare DSH program with the exception of CAHs. There are also 11 categories of non-hospital covered entities that are eligible based on receiving federal funding that include: federally qualified health centers (FQHCs); FQHC “look-alikes”; state-operated AIDS drug assistance programs; Ryan White Comprehensive AIDS Resources Emergency Act clinics and programs; tuberculosis, black lung, family planning, and sexually transmitted disease clinics; hemophilia treatment centers; Title X public housing primary care clinics; homeless clinics; urban Indian clinics; and Native Hawaiian health centers. Covered entities may provide drugs purchased through the 340B program to all eligible patients, regardless of a patient’s payer status and whether the drug is intended for self-administration or administration by a clinician. Discounts have been estimated to range from 20-50 percent of the drug’s cost.

DISCUSSION

Affordability and access to prescription medication is an area of increased focus by Congress and the Trump Administration. In the past year the 340B program has become the subject of significant scrutiny. A central question posed by a number of stakeholders: do the rapidly increasing number of DSH hospitals eligible for the 340B program discounts provide low-income patients the benefit of the prescription drug rebates that they receive? (Other aspects of the 340B program, addressed by the newly adopted AMA policy concerning the 340B program, have also been flagged including manufacturer and covered entity noncompliance with 340B program requirements and insufficient federal agency authority and resources to provide appropriate oversight.)

The Affordable Care Act increased the size and scope of the 340B program by expanding eligibility to more types of hospitals, such as critical access hospitals and sole community hospitals, and expanded Medicaid eligibility. As a result of the latter, the number of hospitals qualifying as DSH hospitals increased as DSH designation is calculated based on a formula that utilizes the number of Medicaid covered patients that a hospital serves. The number of participating unique covered entities has grown from 3,200 in 2011 to 12,722 in October 2017. The number of hospitals has grown significantly, from 591 in 2005 to 2,479 as of October 2017.
There have also been a number of unintended consequences of the 340B program. A 2015 Avalere study found that hospitals participating in the 340B program were more likely than non-340B hospitals to acquire independent physician practices. These acquisitions create financial windfalls for hospitals due to the 340B program yet do not necessarily improve affordability for patients. Patient costs and resultant co-pays/co-insurance and deductibles for care in a hospital outpatient department (HOPDs) can be higher than those in physician offices. (In those instances, patient care in HOPDs is more costly for health insurers too.) Furthermore, some 340B eligible hospitals may have commercial contracts that pay substantially more than the Medicare rate for drugs, so the profit margin can be multiples of the cost of the drug. Patients may face a 20 percent coinsurance on this higher amount. Yet, hospitals eligible for the 340B program obtain drugs at a substantial discount. The 340B program does not require that the hospital pass the savings to uninsured or underinsured low-income patients. To the extent that the hospital does not pass along the savings, the combined payment by insurer and patient provides profit for the 340B hospital; the additional volume generated when 340B hospitals acquire independent physician practices results in even greater profits. There are also reports that hospital systems have acquired 340B program eligible hospitals in order to purchase drugs for their suburban clinics utilizing the discounts even though such clinics do not serve uninsured or underinsured low-income patients.

There have been several congressional hearings on the 340B program convened by the U.S. Senate’s Health, Education, Labor, and Pension (HELP) Committee as well as the U.S. House of Representatives’ Energy and Commerce (E&C) Committee. Testimony offered by the U.S. Government Accountability Office (GAO), the HHS Office of the Inspector General (OIG), and other witnesses included concerns with the 340B program’s: (1) inadequate “patient” definition; (2) eligibility criteria for covered entity; (3) oversight of covered entities and manufacturers; and (4) oversight of the use of contract pharmacies. The lack of program data to assess the extent to which 340B program covered entities are ensuring low-income patients benefit from the rebates and the savings has particularly troubled policymakers and other stakeholders.

In addition to the hearings, over 17 federal bills have been introduced concerning the 340B program in this Congress. A number of the bills would mandate reporting on care provided to low-income individuals and would impose new eligibility requirements for certain categories of covered entities. For example, in December 2017, Representative Larry Buschon (R-IN) introduced H.R. 4710, Protecting Access for Underserved and Safety-net Entities Act (340B PAUSE Act). The bill would impose a moratorium on registration for certain new 340B program hospitals and associated sites. H.R. 4710 would also mandate data collection by covered entities including the number and percentage of insured (by insurer) and uninsured individuals who are dispensed or administered 340B program discounted drugs. In January 2018, Senator Bill Cassidy (R-LA) introduced S. 2312, Helping Ensure Low-income Patients have Access to Care and Treatment Act (HELP Act). The bill would impose a registration moratorium on new non-rural 340B program covered entities and associated sites as well as new eligibility requirements for covered entities. It would also require reports on the level of charity care provided by covered entities. Similarly, in April 2018, Representative Earl Carter (R-GA) introduced H.R. 5598, 340B Optimization Act. The bill would amend the Public Health Service Act to require certain disproportionate share hospital covered entities under the 340B drug discount program submit to HHS reports on low-income utilization rates of outpatient hospital services furnished by such entities.

In order to address the lack of data available directly from 340B program hospital covered entities or HRSA vis-à-vis the benefit to low-income patients, the House E&C Committee Chairman Greg Walden (R-OR) and health subcommittee Chairman Michael Burgess (R-TX) requested a report on the topic from the GAO. On June 18, 2018, the GAO issued the report, Drug Discount Program:
Characteristics of Hospitals Participating and Not Participating in the 340B Program. The report found that:

- In 2016 ... the median amount of charity care provided by all 340B hospitals ... was similar to the median amount provided by all non-340B hospitals, and the median amount of uncompensated care provided by these 340B hospitals was higher than that provided by their non-340B counterparts. But again, the differences between the 340B and non-340B hospitals varied across the different hospital types. For example, while the median amount of uncompensated care provided by 340B general acute care hospitals (340B DSH) was higher than that of their non-340B counterparts, the median amount provided by 340B CAHs was lower than that of non-340B CAHs.

While the report provides additional needed analysis and data, more information is needed concerning the program's implementation and benefit to low-income patients. To ensure the 340B program covered entity criteria aligns with the goal of ensuring low-income patients are able to access affordable treatments, at least one national medical specialty society has recommended that Congress establish new metrics that such entities must meet that are objective, universal, verifiable and align program eligibility with the care provided by the covered entity to indigent and underserved individuals. Consistent with the foregoing, alternative eligibility measures could be calculated by analyzing the amount of charity care provided by hospitals in the outpatient setting. Ultimately, eligibility should be designed to qualify entities based on the amount of care delivered to underserved populations in outpatient settings. This would dovetail with new AMA policy to work with policymakers to establish 340B program eligibility for all physician practices demonstrating a commitment to serving low-income and underserved patients, new covered entity criteria should promote participation by institutions and practices of all sizes in all settings. To advance this goal, ASCO has convened an expert workgroup to develop recommendations for a revised eligibility formula in order to appropriately capture the level of outpatient charity care provided by hospitals, as well as standalone community practices. ASCO will provide policymakers and other stakeholders with the recommendations during the current congressional session.

CONCLUSION

The significant growth of the 340B program, particularly among DSH hospitals, should align with newly adopted HOD policy concerning 340B program and related AMA policies. Specifically, the program should promote access to affordable prescription drugs by low-income patients receiving care from 340B program covered entities. In addition, our AMA should engage with national medical specialty societies to leverage expertise and align recommendations to federal policymakers.

RECOMMENDATIONS

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)

Fiscal Note: Less than $5000

REFERENCES

1 Section 340B of the Public Health Service Act, codified at 42 U.S.C. § 256b.
3 42 U.S.C. § 256b(a)(4)(A)–(K)
4 Id.
5 Id.
6 Id.
9 Id.
11 An Avalere report on Cost of Cancer Care stated that its “risk-adjusted results suggest that treatment for patients receiving chemotherapy in a HOPD costs on average 24 percent more than treatment received in a physician’s office.” Available from http://www.communityoncology.org/pdfs/avalere-cost-of-cancer-care-study.pdf
INTRODUCTION

Resolution 419-A-18, “Violence Prevention,” was introduced by the Washington Delegation. The first and third Resolves, which were referred by the House of Delegates, asked:

That our American Medical Association (1) advocate that a valid permit be required before the sale of all rapidly-firing semi-automatic firearms and (3) study options for improving the mental health reporting systems and patient privacy laws at both the state and federal levels and how those can be modified to allow greater information sharing between state and federal government, law enforcement, schools and mental health professionals to identify, track and share information about mentally ill persons with high risk of violence and either report to law enforcement and/or the National Instant Criminal Background Check System, with appropriate protections.

Accordingly, this report addresses both firearm licensing and mental health reporting requirements.

CURRENT AMA POLICY

As one of the main causes of intentional and unintentional injuries and deaths, the American Medical Association (AMA) recognizes that firearm-related violence is a serious public health crisis in the United States. The AMA has extensive policy on firearm safety and violence prevention. Relevant to this report is existing policy that supports requiring the licensing of firearm owners, including completion of a required safety course and registration of all firearms. The AMA also supports a waiting period and background check for all firearm purchasers.

AMA also 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) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (3) requiring gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (4) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.
BACKGROUND

Council on Science and Public Health Report 4-A-18, “The Physician’s Role in Firearm Safety,” reviewed the epidemiology of firearm morbidity and mortality, identified barriers to physician counseling, discussed the 11th U.S. Circuit Court of Appeals decision, which held that Florida’s Firearm Owners’ Privacy Act violated the First Amendment, explained that there are no state or federal laws that prohibit physicians from counseling patients on firearm safety, outlined the risk factors for firearm injuries, and identified policies that grant the authority to remove firearms from high-risk individuals who already possess them. Because these issues were recently addressed, they are not considered in this report. This report focuses on the issues of licensing of firearm purchasers and mental health reporting.

The National Instant Criminal Background Check System (NICS)

The Brady Handgun Violence Prevention Act of 1993 required the establishment of a computerized system to facilitate background checks on individuals seeking to acquire firearms from federally licensed firearms dealers. The NICS was activated in 1998 and is administered by the Federal Bureau of Investigation (FBI). In 2010, federal and state agencies conducted 10.4 million background checks and more than 150,000 purchases were denied when purchasers were identified as prohibited persons. However, records in the NICS are provided voluntarily by state, local, tribal, and federal agencies. Inconsistencies in states’ reporting of disqualifying records to the NICS, as well as loopholes (i.e., unlicensed dealers) in the requirements for background checks prior to a firearm purchase, contribute to the lack of success in consistently identifying individuals who are disqualified from possessing firearms.

Prohibited Persons and Mental Health

The federal Gun Control Act (GCA) of 1968 makes it unlawful for certain categories of persons to ship, transport, receive, or possess firearms or ammunition. Those categories include, but are not limited to individuals convicted of a felony; unlawful users or those with addiction involving any controlled substance; individuals adjudicated as a “mental defective” or under an order of civil commitment; individuals subject to a court order restraining them from harassing, stalking, or threatening an intimate partner or child of the intimate partner; or persons who have been convicted of a misdemeanor crime of domestic violence. “Adjudicated as a mental defective” is further defined as:

- A determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease: (1) Is a danger to himself or to others; or (2) Lacks the capacity to manage his own affairs. The term shall include – (1) a finding of insanity by a court in a criminal case, and (2) those persons found incompetent to stand trial or found not guilty by lack of mental responsibility (under the Uniform Code of Military Justice).

Furthermore, “committed to a mental institution” is defined as:

- A formal commitment of a person to a mental institution by a court, board, commission, or other lawful authority. The term includes a commitment to a mental institution involuntarily. The term includes commitment for mental defectiveness or mental illness. It also includes commitments for other reasons, such as for drug use. The term does not include a person in a mental institution for observation or a voluntary admission to a mental institution.
It is important to note that a diagnosis of, or treatment for, mental illness does not alone qualify an individual for reporting to the NICS.\textsuperscript{4, 5} Existing federal criteria for firearm-disqualifying mental health records are not perfect. They have been criticized for being both over-inclusive and under-inclusive.\textsuperscript{6} It is the American Psychiatric Association’s position that:

Reasonable restrictions on gun access are appropriate, but such restrictions should not be based solely on a diagnosis of mental disorder. Diagnostic categories vary widely in the kinds of symptoms, impairments, and disabilities found in affected individuals. Even within a given diagnosis, there is considerable heterogeneity of symptoms and impairments.\textsuperscript{7}

Furthermore, individuals with mental illness, when appropriately treated, do not pose an increased risk of violence compared with the general population.\textsuperscript{8} However, mental illness is strongly associated with suicide, which represents nearly 60 percent of firearm-related deaths in the United States.

**DISCUSSION**

**State Licensing Requirements**

Federal law does not require the licensing of firearm purchasers or owners. A number of states have enacted licensing requirements to help prevent prohibited individuals from purchasing firearms. Different types of firearm licensing laws exist in states. Permits-to-purchase (PTP) licensing systems require prospective firearm purchasers to have direct contact with law enforcement or judicial authorities that review the purchase application and verify the passage of a background check.\textsuperscript{9} While similar to PTP laws, license to own firearm laws differ in that the license must remain valid for as long as the person owns the firearm. Firearm safety certificates require completion of a required safety training course as a part of the firearm licensing process in addition to the passage of a background check. Firearm registration laws require individuals to record their ownership of a firearm with a designated law enforcement agency.

PTP laws, which have been enacted in 10 states and the District of Columbia, are the most common type of firearm licensing laws.\textsuperscript{10} In these jurisdictions, both licensed and unlicensed dealers can only sell firearms to individuals with a current PTP license, closing the loophole that exists under federal law. While the licensing requirements vary by state, they generally require an individual to fill out a license or permit application form, submit the form in-person to the licensing authority, and pay the required fees. A background check through the NICS is usually required. Some states also require fingerprints to be taken as a part of the application process. In some jurisdictions (Massachusetts, New York and New Jersey), law enforcement agencies have discretion in denying a permit. If approved, the permit or license is issued. State licensing laws usually apply to specific types of firearms (i.e., handguns or long guns and rifles).

States with PTP laws tend to have lower firearm-related death rates than states without these laws after controlling for demographic, economic and other differences across states.\textsuperscript{11} Evidence suggests that state laws leading to tighter regulation of sale and possession of firearms, including PTP laws, reduce the availability of in-state guns involved in crimes and traced by law enforcement.\textsuperscript{12} Furthermore, criminals who used firearms in places with PTP laws typically acquired them from states with weaker laws.\textsuperscript{13} PTP laws also are associated with reductions in firearm homicide and suicide rates. Connecticut’s PTP law was associated with a 40 percent reduction in firearm homicide rates during the first 10 years the law was in place while there was no evidence for a reduction in non-firearm homicides.\textsuperscript{14} Missouri’s firearm-related homicide rate increased abruptly after the state repealed its PTP handgun licensing law in 2007. The state saw a
25 percent higher rate in the first three years post repeal than during the prior nine years.\textsuperscript{15} A study conducted in large urban counties found that PTP laws were associated with a 14 percent reduction in firearm homicides.\textsuperscript{16} PTP law enactment was associated with protective effects against firearm suicides in Connecticut, and PTP repeal in Missouri was associated with increased risk of firearm suicides.\textsuperscript{17}

**Mental Health Reporting**

In 2007, the NICS Improvement Amendments Act (NIAA) authorized the Attorney General to provide grants to states to improve electronic access to records and incentivize states to turn over records of persons prohibited from possessing firearms.\textsuperscript{18} The NIAA created the NICS Act Record Improvement Program (NARIP), which provides funding to states to ensure that the appropriate mental health records are included in the NICS. In November of 2011, a report by Mayors Against Illegal Guns found that for complex legal and logistical reasons, records of serious mental health and substance use problems that disqualify people from firearm ownership have been difficult to capture in NICS.\textsuperscript{19} In 2012, the Government Accountability Office examined states’ progress in reporting mental health records to the NICS. They found that from 2004 to 2011, the total number of mental health records that states made available to the NICS increased by 800 percent – from 126,000 to 1.2 million records.\textsuperscript{20} However, the increase largely reflected the efforts of 12 states. A variety of technological, coordination, and legal (i.e., privacy) challenges limit states’ ability to report mental health records.\textsuperscript{21}

Technological challenges are relevant to mental health reporting because the records originate from multiple sources within a state (i.e., courts, private hospitals, state mental health agencies) and are not captured by a single agency.\textsuperscript{22} In terms of legal challenges, some states indicated that the lack of explicit state-level authority to share mental health records with NICS was an impediment.\textsuperscript{23} Coordination challenges involved getting hospitals and departments of mental health to collaborate with law enforcement, who make the majority of records available to NICS.\textsuperscript{24} Non-criminal justice entities may not be aware of NICS reporting requirements, or, if they are aware, may be unfamiliar with how to report.

**Relationship to NARIP Funding.** NARIP funding has been provided to states to address these barriers. In order to receive NARIP funding, states are required to have a “relief from disabilities statute” whereby firearm purchasing rights can be restored to a person who had them removed because of a mental health adjudication or involuntary commitment. Information on the level of funding by state from FY 2009-2017, as well as promising practices for improved record reporting to the NICS, are available on the Bureau of Justice Statistics website.\textsuperscript{25} As of July 2015, there were 3.8 million state-submitted mental health records in the NICS.\textsuperscript{26} Forty-three states have enacted laws that require (32) or authorize (11) the reporting of mental health records to NICS. The largest increase in reported mental health data from 2008 to 2015 occurred in states with a reporting requirement.\textsuperscript{27} Twenty of the 26 states with the largest increase in mental health data also received NARIP funding.

**HIPAA Considerations.** In 2013 there was considerable focus on whether the Health Insurance Portability and Accountability Act (HIPAA) or state privacy laws were an obstacle to the submission of mental health records to NICS.\textsuperscript{28} On January 4, 2016, the U.S. Department of Health and Human Services modified HIPAA to expressly permit certain covered entities to disclose to the NICS the identities of those individuals who, for mental health reasons, are prohibited by federal law from having a firearm.\textsuperscript{29} The final rule noted that creating a limited express permission in the HIPAA Privacy Rule to use or disclose certain information relevant to the federal mental health prohibitor for NICS purposes was necessary to address barriers related to HIPAA, and to ensure
that relevant information can be reported for this important public safety purpose. The rule
specifically prohibits the disclosure of diagnostic or clinical information from medical records or
other sources, and any mental health information beyond the indication that the individual is
subject to the federal mental health prohibitor, and does not apply to most treating providers.30

Education Records. The Family Educational Rights and Privacy Act (FERPA) is a Federal law that
protects the privacy of student education records. Due to the nature of mental health records
reported to the NICS, schools are not likely to be among the organizations reporting. However,
FERPA does have an exception that allows educational agencies and institutions to disclose
personally identifiable information from education records to appropriate parties in connection with
an emergency if knowledge of the information is necessary to protect the health and safety of the
student or other individuals.31 The information may be disclosed to any person whose knowledge
of the information is necessary to protect the health or safety of the student or other individuals.

CONCLUSION

The AMA House of Delegates adopted policy at A-18 to require the licensing of all firearm
owners. PTPs are a type of license, thus a separate policy requiring a permit prior to the sale of
rapidly-firing semi-automatic firearms is not necessary. This requirement is encompassed in the
existing licensing policy. However, amending the policy to clarify that permits are a type of license
would be helpful to avoid future confusion.

In terms of mental health reporting, several national reports have identified the technological,
coordination, and legal (i.e., privacy) challenges that limit states’ ability to report mental health
records to the NICS. In recent years, progress has been made to increase the reporting of these
records through the enactment of state reporting requirements, federal grants to states to address
collaboration through state level task forces focused on NICS improvement, training to help
identify the records that should be reported, automated transfer of mental health data to the NICS,
and clarification of federal privacy laws. In addition, legislation was enacted by Congress as part of
the FY 2018 Omnibus Appropriations bill—the Fix NICS Act of 2017—that, among other
provisions, requires states to develop a plan to ensure maximum coordination and automation of
the reporting the NICS.32 The law also reauthorizes NARIP through FY 2022.33 While existing
AMA policy supports a waiting period and background checks for all firearm purchases, AMA
policy does not currently address deficiencies in the current NICS system.

In addition to the NICS system, it is important to have policies in place that remove current access
to firearms rather than just preventing the purchase of new firearms by individuals who are at high
or imminent risk for harming themselves or others. The Council on Science and Public Health
report and recommendations on “The Physician’s Role in Firearm Safety,” at A-18 led to the
adoption of policy addressing the removal of firearms from high risk individuals, which includes
support for gun violence restraining orders. Since overlapping policy on gun violence restraining
was adopted and appended to Policy H-145.996, “Firearm Availability.” We recommend
streamlining AMA policy in this area and removing the reference to “red flag” laws.
RECOMMENDATIONS

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 support requiring 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 in court for their rights to be restored. (Modify Current HOD Policy)


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)

Fiscal Note: Less than $500.
REFERENCES


24 Goggins B. and Gallegos A. State Progress in Record Reporting for Firearm-Related Background Checks: Mental Health Submissions. SEARCH and the National Center for State Courts. February 2016.

26 Goggins B. and Gallegos A. State Progress in Record Reporting for Firearm-Related Background Checks: Mental Health Submissions. SEARCH and the National Center for State Courts. February 2016.
27 Goggins B. and Gallegos A. State Progress in Record Reporting for Firearm-Related Background Checks: Mental Health Submissions. SEARCH and the National Center for State Courts. February 2016.
29 81 FR 382
31 34 CFR 99.36
32 Public Law No: 115-141.
33 Public Law No: 115-141.
WHEREAS, AMA Policy H-180.956, “Physician Privileges Application – Timely Review by Managed Care,” states Medicare, Medicaid, and managed care organizations should retroactively compensate physicians for services rendered from the date of their credentialing; and

WHEREAS, HB 139 was successfully passed by the 2018 Virginia General Assembly and signed into law by Governor Northam. This allows physicians who are waiting to be credentialed by a health plan to see patients and retroactively receive payments if they are ultimately credentialed; and

WHEREAS, Physicians awaiting credentialing could be reimbursed $1000 per day during the credentialing process (Virginia Medical News – Spring/Summer 2018); therefore be it

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. (Directive to Take Action)

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

Received: 08/28/18

RELEVANT AMA POLICY

Physician Privileges Application - Timely Review by Managed Care H-180.956
Our AMA policy is that: (1) final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed; (2) health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification; and (3) Medicare, Medicaid, and managed care organizations should (a) make final physician credentialing determinations within 45 calendar days of receipt of a completed application; (b) grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered from the date of their credentialing.
Whereas, The opioid-overdose epidemic has had a devastating impact throughout the United States and currently claims about 115 lives per day (1); and

Whereas, The Centers for Disease Control and Prevention in August 2018 reported a record 72,000 overdose deaths in 2017 (2); and

Whereas, Medications for opioid use disorder can facilitate recovery and prevent deaths (3); and

Whereas, Great Britain, Canada and Australia have successfully made methadone available by prescription, enhancing access to this valuable therapy (1); and

Whereas, Limited experience in the United States over a 10-year period has demonstrated the success of such a primary care approach for treatment of opioid use disorder (1); and

Whereas, In 2001, there was a six-month randomized controlled trial that supported the success of such a primary care based approach (4, 5); and

Whereas, Enhancing the opportunity for primary care practices to prescribe methadone might increase the availability of such treatment in non-urban populations who lack access to methadone clinics; and

Whereas, AMA Policy H-95.957 supports the concept of “…properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal….”; therefore be it

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 (Directive to Take Action); 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. (Directive to Take Action)

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

Received: 09/21/18
References:

RELEVANT AMA POLICY

Methadone Maintenance in Private Practice H-95.957
Our AMA: (1) reaffirms its position that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further; (2) supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed; (3) encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users; (4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and (5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-18)

Introduced by: Resident and Fellow Section

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

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to protect a subset of identifiable information known as Protected Health Information (PHI) and in 2009 HIPAA was expanded and strengthened by the Health Information Technology for Economic and Clinical Health Act (HITECH Act); and

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

Whereas, All technologies designed to be HIPAA-compliant must adhere to two rules: the 'Standards for Privacy of Individually Identifiable Health Information' known as the Privacy Rule, and the 'Security Standards for the Protection of Electronic Protected Health Information' known as the Security Rule1; and

Whereas, Baseline cell phone security, text messaging and telecommunication technologies are lacking in necessary security measures to meet the standards for HIPAA-compliance2,3; and

Whereas, There are an increasing number of HIPAA-compliant applications related to patient health and communication with several versions of developer’s guides for HIPAA-compliance distributed online for several years; and

Whereas, Despite evidence from studies showing perceived improvement in provider communication with HIPAA-compliant text messaging applications, more than 50% of residents report routinely text messaging protected health information (PHI) in violation of HIPAA3,4; therefore be it

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. (New HOD Policy)

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

Received: 09/27/18

References:
1 https://www.informationweek.com/healthcare/security-and-privacy/hipaa-compliance-what-every-developer-should-know/a/d-id/1297180
2 http://library.ahima.org/doc?oid=105342#.WbdYl9hOmEc
RELEVANT AMA POLICY

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)

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.

Guidelines for Patient-Physician Electronic Mail 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)
Whereas, The Association of American Medical Colleges predicts a physician shortage of more than 100,000 doctors by the year 2030; and

Whereas, International Medical Graduates (IMGs) are more likely to practice in primary care specialties than US medical graduates; and

Whereas, Foreign-born IMGs were more likely to practice in rural underserved areas than US born IMGs; and

Whereas, The Educational Commission for Foreign Medical Graduates (ECFMG) sponsors approximately 10,000 J-1 visas annually; and

Whereas, The ECFMG prohibits physicians with a J-1 visa from moonlighting based on the US Code of Federal Regulations 22CFR62.16, and subsequently prohibits physicians with J-1 visas privileges to bill for services rendered; and

Whereas, Providing physicians with a J-1 visa billing privileges and the ability to moonlight may improve the access to care in certain areas; therefore be it

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. (New HOD Policy)

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

Received: 09/27/18

RELEVANT AMA POLICY

Employment of Non-Certified IMGs H-255.970

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs.

Citation: (Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)

References:
1 Research Shows Shortage of More than 100,000 Doctors by 2030. Available at: https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-loomi ng-physician-shor/.
2 International Medical Graduates and The Primary Care Workforce For Rural Underserved Areas. Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.2.255.
MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-18)

Introduced by: International Medical Graduates Section

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

Referred to: Reference Committee B
(Chair, Francis P. MacMillan, Jr., MD)

Whereas, Our AMA has supported legalization of the Deferred Action for Early Childhood Arrival (DACA) children brought to this country illegally by their parents; and

Whereas, Our AMA has supported reducing the backlog of granting of green cards for permanent residency which sometimes has been delayed for several years. This delay leads to their children turning 21 years of age and thus becoming illegal; and

Whereas, There are thousands of children who arrived in this country with their parents legally, however once they turn 21 years of age they automatically become illegal. They are then called DALCA (Deferred Action for Legal Childhood Arrival); and

Whereas, There are 80,000-100,000 children that fall into this category; and

Whereas, Many of these DALCA children are in medical schools or have already graduated from U.S. medical schools, but are subject to deportation because they are considered illegals. Many of these DALCA children have matched in residency programs but have been held back due to their lack of proper legal status; and

Whereas, There is bipartisan support in Congress for these children which has not garnered media headlines; therefore be it

RESOLVED, That our American Medical Association support legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (New HOD Policy); 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. (Directive to Take Action)

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

Received: 09/28/18

References:
“Consideration of Deferred Action for Childhood Arrivals (DACA)”
“Deferred Action for Childhood Arrivals: Response to January 2018 Preliminary Injunction”
RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation’s Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986
1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.
(Res. 305, A-15; Appended: Late Res. 1001, I-16)
Whereas, Reporting data under the Merit-based Incentive Payment System (MIPS) increases the administrative burden on physicians and takes time away from patient care; and

Whereas, The maximum potential payment penalty under MIPS will incrementally increase to 9%; and

Whereas, Many physician practices that serve Medicare beneficiaries cannot sustain additional reductions in their Medicare payments; and

Whereas, Small and medium-sized physician practices are likely to be disproportionately impacted by penalties under MIPS; and

Whereas, Participation in pay-for-performance programs should not be compulsory; therefore be it

RESOLVED, That our American Medical Association advocate to repeal all potential penalties associated with the MIPS program. (Directive to Take Action)

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

Received: 09/27/18
RELEVANT AMA POLICY

Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program D-395.998
1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.
Citation: Res. 247, A-18

Reducing MIPS Reporting Burden D-395.999
Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physicians choosing) within the calendar year.
Citation: Res. 236, A-18
Whereas, Affirmative action is a race-conscious recruitment policy designed to equalize access to jobs and professions such as medicine and is based on the premise that relief from illegal racial discrimination is not enough to remove the burden of second-class citizenship from underrepresented minority groups;¹ and

Whereas, Affirmative action has been identified as a potent method for ameliorating racial disparities and increasing diversity in public universities;²,³ and

Whereas, University enrollment is directly correlated with attaining higher social status;⁴ and

Whereas, Diversity in the student body fosters a greater understanding of patient populations and preparation for medical care to an increasingly multicultural society;⁵,⁶ and

Whereas, Underrepresented minority physicians are more likely to practice in underserved areas and tend to serve populations with higher percentages of medically indigent patients.;⁷-⁹ and

Whereas, Affirmative action has shown to increase medical practice in underserved areas with minority populations and providing better healthcare for various communities;¹⁰ and

Whereas, Several states that have instituted bans on affirmative action have experienced subsequent decreases in college enrollment by minority students, completion of STEM degrees by minority students, and representation of minority students among matriculating medical school students;²,³,¹¹,¹² and

Whereas, In 1978, 2003, and 2016 the supreme court upheld affirmative action in the cases of Regents of the University of California v. Bakke, Grutter v. Bollinger, and Fisher v. The University of Texas at Austin, respectively, allowing race to be one of several factors in college admission policy;¹³-¹⁵ and

Whereas, Although AMA policy establishes a significant precedent to support undergraduate education as a means to produce medical school matriculants (H-60.917, H-350.979, H-200.985), existing policy falls short of addressing the necessity of affirmative action as mechanism for equality at the undergraduate level, which is necessary to bolster the pool of minority students able to apply to a medical program; and

Whereas, The Department of Justice has announced the intent to investigate and potentially sue institutions utilizing affirmative action, threatening the principles of racial equality in education that our AMA supports;¹⁶ therefore be it
RESOLVED, That our American Medical Association oppose legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population. (New HOD Policy)

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

Received: 09/28/18

References:

5. Lakhan SE. Diversification of U.S. medical schools via affirmative action implementation. BMC Medical Education. 2003;3(1).
10. Lakhan SE. Diversification of U.S. medical schools via affirmative action implementation. BMC Medical Education. 2003;3(1).

RELEVANT AMA POLICY

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.
Citation: Res. 910, I-16

Equal Opportunity H-65.968
Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.
Citation: (CCB/CLRPD Rep. 4, A-13)
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.

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.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18
Whereas, Our AMA recognizes that social determinants of health, including circumstances of early life, social gradient, unemployment, and social exclusion, should be taught in medical school (H-295.874) and built in to payment models (H-160.896); and

Whereas, Residents of rural areas in the United States tend to be older and sicker than their urban counterparts with higher rates of poverty, less access to healthcare, and higher likelihood of dying from 5 leading causes of death when compared to their urban counterparts; and

Whereas, 23 million Americans live in areas that do not have broadband internet access; and

Whereas, Broadband internet provides access to resources not only for health care but also for economic growth and job opportunities, educational opportunities, and government services; and

Whereas, Our AMA has a broad swath of policies which encourage the use of, and pay for, telemedicine, which requires broadband internet; and

Whereas, The Federal Communications Commission Connect2Health Task Force is currently exploring the intersections of health and technology in rural areas; therefore be it

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

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

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students’ appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students’ cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.
Citation: CME Rep. 11, A-06; Reaffirmation A-11; Modified in lieu of Res. 908, I-14; Reaffirmed in lieu of Res. 306, A-15; Reaffirmed: BOT Rep. 39, A-18

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
Citation: BOT Rep. 39, A-18
Whereas, Although the AMA has existing policy on the education and prevention of sexual assault on college campuses, many adolescents have become victims of sexual assault and AMA policy does not explicitly address this topic for this age group; and

Whereas, More than forty-two percent (42.2%) of forced sexual violence victims are assaulted before they are 18 years old; and

Whereas, More than eleven percent (11.3%) of female high school students and 3.5% of male high school students responding to the 2017 National Youth Risk Behavior Survey reported victimization by forced sex; and

Whereas, The 2017 National Youth Risk Behavior Survey also notes the incidence of forced sex has failed to improve over the last decade among high school students; and

Whereas, A significantly higher percentage of female students (10.7%) reported this sexual dating violence in the past year compared to male students (2.8%); and

Whereas, Both forced sex and sexual dating violence disproportionately affects sexual minorities in high school with 21.9% of lesbian, gay, or bisexual youth reporting forced sex (compared to 5.4% of heterosexual youth); and

Whereas, At least two states (California and Missouri) require education of high school students regarding consent as part of a mandate to teach about healthy relationships, and several others have recently considered such legislation as the majority of U.S. teens may graduate high school without any formal instruction on consent; therefore be it

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. (Directive to Take Action)

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

Received: 09/28/18
References:

RELEVANT AMA POLICY

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted
infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
Citation: CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Addressing Sexual Assault on College Campuses H-515.956
Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.
Citation: Res. 402, A-16; Appended: Res. 424, A-18
Whereas, Ethical guidelines for transplantation are set forth by our AMA, the World Medical Association and the World Health Organization; the medical profession has the responsibility to protect the rights and interests of patients who need and seek transplant surgery, as well as to protect the rights and interests of organ donors whose organs may have been procured in an unethical manner; and

Whereas, China is second only to the United States as the country that performs the largest number of transplants and thus has a particular responsibility to act ethically and transparently regarding organ transplants; and

Whereas, Systematic, state-sanctioned organ harvesting from executed prisoners and prisoners of conscience in China has occurred with the knowledge of the Chinese government; and there are also reports about forced organ harvesting from Uighurs, House Christians, Tibetans and Falun Gong practitioners; and

Whereas, The U.S. Congress passed House Resolution 343 in 2016, calling for an end to forced organ harvesting from Falun Gong prisoners of conscience in China; and the European Parliament also passed Written Declaration 48 in 2016, calling for investigations and an end to forced organ harvesting from Falun Gong prisoners of conscience in China; and

Whereas, Doctors Against Forced Organ Harvesting (DAFOH), a medical NGO that was nominated twice for a Nobel Peace Prize, collected over 3 million signatures for a petition to the U.N. High Commissioner for Human Rights, calling for an end to forced organ harvesting in China; and

Whereas, Chinese transplant numbers have increased dramatically and transplant tourism has become a lucrative source of income in China, leading to a rapid expansion of the transplant infrastructure in China; and China has declared the Hainan Islands to be a special economic zone for medical tourism; therefore be it

RESOLVED, That 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 (New HOD Policy); 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 (Directive to Take Action); 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). (Directive to Take Action)

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

Received: 09/27/18

RELEVANT AMA POLICY

E-6.1.1 Transplantation of Organs from Living Donors

Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.

Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.

Physicians who participate in donation of nonvital organs and tissues by a living individual should:
(a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donors well-being.
(b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
(c) Carefully evaluate prospective donors to identify serious risks to the individuals life or health, including psychosocial factors that would disqualify the individual from donating; address the individuals specific needs; and explore the individuals motivations to donate.
(d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.
(e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.
(f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.
(g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:
   (i) the minor agrees to the donation;
   (ii) the minor’s legal guardians consent to the donation;
   (iii) the intended recipient is someone to whom the minor has an emotional connection.
(h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.
(i) Inform the prospective donor:
(i) about the donation procedure and possible risks and complications for the donor;
(ii) about the possible risks and complications for the transplant recipient;
(iii) about the nature of the commitment the donor is making and the implications for other parties;
(iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the
organ or collect tissue, whether the context is paired, domino, or chain donation; and
(v) that if the donor withdraws, the health care team will report simply that the individual was not a
suitable candidate for donation.

(j) Obtain the prospective donor’s separate consent for donation and for the specific intervention(s) to
remove the organ or collect tissue.

(k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors
should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care
associated with the donation only.

(l) Permit living donors to designate a recipient, whether related to the donor or not.

(m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be
expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.

(n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain
in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation
to a stranger include:

(i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired
donation (“organ swap,” as when donor-recipient pairs Y and Z with incompatible blood types are
recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);

(ii) domino paired donation;

(iii) nonsimultaneous extended altruistic donation (“chain donation”).

(o) When the living donor does not designate a recipient, allocate organs according to the algorithm that
governs the distribution of deceased donor organs.

(p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel
donation arrangements that involve many patients and in which donation-transplant cycles may be
extended over time (as in domino or chain donation).

(q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs
of psychological distress during screening and after the transplant is complete.

(r) Support the development and maintenance of a national database of living donor outcomes to support
better understanding of associated harms and benefits and enhance the safety of living donation.

AMA Principles of Medical Ethics: I,V,VII,VIII
Issued: 2016
Whereas, Sudden cardiac arrest (SCA) affects over 40,000 people in the public environment annually in the United States and early and prompt bystander automated external defibrillator (AED) use has been shown to be key for survival from SCA; and

Whereas, Current research have shown that AEDs are used in less than 5% of public SCA events; and

Whereas, Despite efforts to establish AED availability in schools, workplaces and public spaces (as supported by AMA Policy H-130.938), studies have shown that the majority of the public either cannot identify an AED or are not aware of where AEDs are located; and

Whereas, Due to the combination of inadequate public education about AED use, presence of labeling on AEDs that state "Trained Responders Only", and variations in state legislation with respect to legal protection for "Good Samaritans" who use AEDs, most laypersons are not aware that AEDs can be used by non-medical professionals; therefore be it

RESOLVED, That our American Medical Association update its policy on cardiopulmonary resuscitation 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 (New HOD Policy); 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 (Directive to Take Action); 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. (Directive to Take Action)

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


RELEVANT AMA POLICY

**Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938**

Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held; (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events; (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (8) supports the development and use of universal connectivity for all defibrillators; and (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use.

Citation: (CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15)
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-18)

Introduced by: Medical Student Section

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

Referred to: Reference Committee B
( Francis P. MacMillan, Jr., MD, Chair)

Whereas, 1,981 people were injured and 590 people were killed during mass shootings in 2017;¹ and

Whereas, Research suggests that an incident of a mass shooting increases the probability of another mass shooting in the immediate future, with the increased probability lasting for an average of thirteen days and abetting an average of 0.30 new events, suggesting a contagion effect;²,³ and

Whereas, The contagion effect was previously demonstrated in suicides in the mid-1990s and led to the development of media coverage guidelines by the CDC and more recently by the WHO;⁴,⁵,⁶ and

Whereas, Multiple media organizations, including Associated Press Managing Editors and the National Press Photographers Association, have contributed to the publication and adherence of reporting guidelines for suicide that largely reflect the CDC’s published guidelines;⁷,⁸ and

Whereas, Appropriate media coverage of suicide may lead to a reduction in suicide rates, an effect known as the Papageno effect;⁹-¹² and

Whereas, Analysis of media coverage of mass shootings followed by copycat incidents of mass shootings indicate a media contagion effect;²,³,⁹,¹³ therefore be it

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. (New HOD Policy)

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

Received: 09/28/18
References:

RELEVANT AMA POLICY

Mass Media Violence and Film Ratings H-515.974
Redressing Shortcomings in the Current System: The AMA: (1) will speak out against the excessive portrayal of violence in the news and entertainment media, including newscasts, movies, videos, computer games, music and print outlets, and encourage the depiction of the medical, social and legal consequences of violence by the media; (2) advises physicians to counsel parents about the known effects of media violence on children's behavior and encouraging them to reduce the amount of violent programming viewed by their children; (3) monitors changes in the current ratings system and working through state medical societies to inform physicians and their patients about these changes; and (4) supports all other appropriate measures to address and reduce television, cable television, and motion picture violence.
Citation: BOT Rep. 18, A-94; Modified: Res. 417, I-95; Appendix: Sub. Res. 419, A-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation: A-13 ; Reaffirmation: 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.


Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

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

Physicians and the Public Health Issues of Gun Safety D-145.997
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Citation: (Res. 410, A-13)

Epidemiology of Firearm Injuries D-145.999
Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Our AMA endorses the specific recommendations made by an interdisciplinary, interprofessional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Citation: Res. 214, I-16
Whereas, 1.7 million children live in homes with unlocked, loaded firearms and 1 in 3 homes with children have one or more firearms;1 and

Whereas, A study found that 50.2% of children were often in homes that contained firearms, including their own and other homes;2 and

Whereas, Studies on unintentional shootings have found that from 2005 to 2014, roughly 20,000 American minors were killed or seriously injured in accidental shootings; the majority of those killed in these tragic accidents were aged 12 or younger;3,4 and

Whereas, Studies have found that in firearm-owning households with children, there exists a significant reporting gap between those who actually own the firearm and those who do not regarding the type, number, and storage status of firearms in the home;5,6 and

Whereas, In some cases, the parent who does not own the firearm may be unaware that there is a firearm in the house at all;5,8 and

Whereas, The American Academy of Pediatrics (AAP) recommends that pediatricians include questions about the presence and availability of firearms in their patient history and urge parents owning firearms to take action to prevent children from gaining access to those firearms;7 and

Whereas, AMA Policy H-145.990 encourages physicians to educate patients on the dangers of firearms to children, but H-145.990 does not address the issue of disparities in reporting firearms between adults in households;8 and

Whereas, Various firearm product safety features exist that have proven to reduce youth firearm injuries, such as grip safeties, magazine disconnect devices, and personalization of firearms;9 and

Whereas, A magazine disconnect device physically prevents a firearm from being discharged if the magazine has been taken out, even if the chamber still has a round in it;10 and

Whereas, The U.S. General Accounting Office estimates 31% of accidental firearm deaths might be prevented by the addition of a child-proof safety lock (8%) and a loading indicator (23%), which indicates whether a firearm is loaded and if it still contains rounds in the chamber;9 and
Whereas, The AAP’s Council on Injury, Violence, and Poison Prevention recommends safe storage and firearm safety features (i.e. trigger locks, lock boxes, gun safes) and supports the funding of research related to the prevention of firearm injury; and

Whereas, The California Department of Justice declared any center-fire semi-automatic pistol to be an “unsafe handgun” if it does not have a chamber load indicator or a magazine disconnect mechanism; and

Whereas, Research spending on firearm injuries conducted by the CDC fell by 96% from 1996 to 2012; and

Whereas, A study concluded that between 2004 and 2015, research on national firearm violence was significantly underfunded and understudied relative to other leading causes of death, receiving less than 1.6% of the $1.4 billion researchers predicted should be allocated to study a public health issue with a similar number of deaths annually; and

Whereas, Existing AMA policy H-145.979 supports legislation that holds firearm owners legally responsible for injury or death caused by a child gaining access to a firearm; and

Whereas, Child Access Prevention (CAP) laws, which encourage firearm owners to be conscious of how they store their firearms, may be more preventive than AMA policy because they range from strict laws that hold gun owners criminally liable when a child could likely gain access to their gun to more lenient forms that only hold gun owners criminally liable if a child actually obtains or uses the gun; and

Whereas, CAP laws are currently active in twenty-seven states as well as Washington D.C.; and

Whereas, Most states that enacted CAP laws experienced greater declines in the rate of unintentional firearm deaths for children ages 0 to 14 compared with states not enacting the laws; and

Whereas, Only states with felony prosecution for violation of CAP laws had statistically significant declines in unintentional firearm deaths when adjusted for firearm prevalence; and

Whereas, when CAP laws were implemented, self-inflicted firearm injuries fell by 64% for youth ages 18 and under, but did not decrease for adults based on data from the Agency for Healthcare Research and Quality’s Nationwide Inpatient Sample (NIS); therefore be it

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

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

Date Received: 09/24/18

REFERENCES:

RELEVANT AMA POLICY:

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.
Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

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.
Citation: 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
Whereas, Firearm deaths are a leading cause of preventable suicide, homicide, injury and
disability in the USA;\(^{ii}\) and

Whereas, In the USA in 2016, there were on average 97 firearm deaths per day, 35,476 total,\(^{i}\)
two thirds of which were suicides affecting mostly young black men and older white men;\(^{i,ii}\) and

Whereas, In the ten years ending in 2016, deaths from firearms totaled more than the
cumulative deaths of American soldiers in WW II;\(^{ii}\) and

Whereas, The Second Amendment to the U.S. Constitution specifies, “A well-regulated militia
being necessary to the security of a free state, the right of the people to keep and bear arms
shall not be infringed;”\(^{iii}\) and

Whereas, A militia is “generally an army or some other fighting organization of non-professional
soldiers, citizens of a nation, or subjects of a state, who can be called upon for military service
during a time of need … .”;\(^{iv}\) and

Whereas, The Second Amendment to the U.S. Constitution literally mandates that such militia
be “well-regulated;” and

Whereas, Firearm regulation that does not violate the Second Amendment to the U.S.
Constitution is not difficult to imagine; and

Whereas, A recent state-of-the-art systematic review of firearm regulation in the USA showed
that firearm regulation was generally associated with decreased rates of firearm homicides;\(^{ii}\) and

Whereas, In that same review, laws that particularly strengthened background checks and
permit-to-purchase are associated with firearm homicide reductions of 29-40%;\(^{ii}\) and

Whereas, The U.S. Congress in 1996 inserted language into the Centers for Disease Control
and Prevention appropriation bills that essentially prevented it from conducting and funding
firearm-related research;\(^{v}\) and

Whereas, Firearms are exceedingly efficient and lethal killing instruments easily classifiable as
extremely hazardous to the health of the public; and

Whereas, U.S. physicians have begun to organize to promote firearm legislation and regulation\(^{vi}\)
suggesting the time for action by organized medicine has arrived; therefore be it
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 (New HOD Policy); and be it further

RESOLVED, That our AMA oppose barriers to firearm safety. (New HOD Policy)

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

Received: 09/25/18

RELEVANT AMA POLICY

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 use 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.

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.
Epidemiology of Firearm Injuries D-145.999
Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.
Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Data on Firearm Deaths and Injuries H-145.984
The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.
Citation: (Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13)

Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994
Our AMA will provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.
Citation: Res. 201, I-16

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.
Citation: 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

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.
Citation: Res. 1011, A-16; Reaffirmation: A-18

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4 https://en.wikipedia.org/wiki/Militia, accessed January 29, 2018
Whereas, The Medical Home model for care has been demonstrated to improve patient outcomes and reduce total cost of care; and

Whereas, Technologic advances are empowering physician practices to extend their reach to care for families in innovative ways including Telehealth; and

Whereas, Current scope of licensure in the majority of states limits physician practice abilities to continue to meet the needs of their families when they travel outside the state in which the physician is licensed; and

Whereas, Some states have joined the Interstate Medical Licensure Compact to facilitate multistate licensure for physicians; and

Whereas, Payers provide telehealth options for patients who need to access primary care services at times when access to the office of the primary care physician is difficult or impossible; and

Whereas, Most primary care physicians are available to talk with patients, or participate in telehealth primary care encounters, on a 24-7 basis; and

Whereas, Entrepreneurial telehealth for-profit entities are contracting with payers to provide inferior quality telehealth primary care, delivered by non-physician providers, for patients; and

Whereas, The primary care physician who knows the patient and has 24-7 access to the medical records of the patient will provide higher quality and more cost-effective health care for the patient than will an out-of-state urgent care center, a hospital emergency department, or a for-profit telehealth entity; therefore be it

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.

(Directive to Take Action)

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

Received: 10/10/18
Whereas, The Competitive Acquisition Program (CAP) was introduced in 2006 as a voluntary program in which physicians have the option to acquire drugs from vendors who are selected in a competitive bidding process¹; and

Whereas, CAP was intended to save physicians time and paperwork, while also lowering drug costs for beneficiaries and the Medicare program; and

Whereas, CAP was suspended by CMS due to lack of vendor competition, lack of physician participation and limited cost savings; and

Whereas, The CMS Center for Medicare and Medicaid Innovation (CMMI) issued a Request for Information (RFI) in July 2018 seeking public feedback on leveraging the authority for the CAP for Part B drugs for a potential CMS Innovation Center model²; and

Whereas, CAP modifications must protect patients and practices from unexpected financial toxicity; therefore be it

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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. (New HOD Policy)

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

Received: 10/11/18

RELEVANT AMA POLICY

Strengthening Medicare Through Competitive Bidding H-330.886
1. Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program:
a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries.
b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks.
c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses.
d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region.
e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area.
f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums.
g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans.
2. Our AMA supports using a competitive bidding process to determine federal payments to Medicare Advantage plans.
Citation: (CMS Rep. 7, I-13)
Whereas, The Administration’s “American Patients First Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs” proposes moving drugs from Medicare Part B to Part D if the move would achieve savings; and

Whereas, 9 million Part B beneficiaries do not have Part D coverage¹ and would therefore be at risk of losing coverage or experiencing higher out-of-pocket costs if this were implemented; and

Whereas, Co-insurance and out-of-pocket costs for therapies provided under Medicare Part D plans are typically higher than cost for therapies covered under Part B and that difference can be financially devastating for patients; and

Whereas, Shifting drugs from Part B to Part D would heighten the role that pharmacy benefit managers (PBMs) play in patient care even though they already generate issues such as treatment delays, medication switching without physician notification, and unnecessary administrative burdens; and

Whereas, Most Part B beneficiaries have supplemental insurance through Medigap programs that assist with Part B cost sharing and would not assist with Part D cost sharing; and

Whereas, There is insufficient data to suggest that moving Part B drugs to Part D would result in savings, as Acumen², Avalere³ and HHS⁴ studies all vary on the outcome of this move; and

Whereas, Physician payments for patient services and reimbursement for drugs together form the total resources available for practices to treat patients, thus it is vital to have an effective system for drug coverage in order to ensure optimal care and patient outcomes; therefore be it

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

RELEVANT AMA POLICY

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904
1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.
Citation: Res. 241, A-16
Whereas, The stated purpose of tort mediated malpractice litigation is threefold:
1. To compensate patients harmed during the course of medical care;
2. To identify and hold accountable doctors and other clinicians for provision of inappropriate or unsafe care;
3. To make medical care safer through exposure of negligent and flawed practice; and thus identify areas for improvement; and
4. Patients generally have no recourse other than medical tort actions to be made whole after medical injury; and
5. Linking compensation for harm to liability for negligence encourages lawsuits when there is no causal linkage between care and outcome (e.g. most cases of cerebral palsy); and
6. The tort system typically takes 3 years to resolve medical malpractice cases and usually in favor of defendants leaving most harmed patients uncompensated at the end of a long, inefficient and expensive process; and
7. Only a small number of medical errors trigger a tort action leaving most cases of medical harm unaddressed; and
8. Most medical injuries are not the result of negligence; and
9. The usual course of litigation over adverse outcomes sets patients and their doctors in adversarial positions when they should be most aligned to respond therapeutically; and
10. According to the IOM’s “To err is human” report, “...clinicians working in a culture of blame and punishment do not report all errors, primarily because they fear punishment ... Fears of reprisal and punishment have led to a norm of silence. But silence kills, and health care professionals need to have conversations about their concerns ... including errors and dangerous behavior of coworkers. ... When individuals and organizations are able to move from individual blame toward a culture of safety, where the blame and shame of errors is eliminated and reporting is rewarded, organizations are enabled to institutionalize reporting systems and increase reporting of all types of errors. ... clinicians and others must know that safety can be improved by non-punitive reporting of error and that organizational flaws cause errors. 

1 https://www.cdc.gov/ncbddd/cp/causes.html
2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3576054/
Whereas, Research has shown a 5% cost reduction in hospital costs when the threat of tort litigation is removed\(^3\); and

Whereas, Our AMA does have considerable policy on medical liability reform (H-435.973, H-435.969, D 435.992), but none of these address the type of reform that is suggested below for further study; therefore be it

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) (Directive to Take Action); 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. (Directive to Take Action)

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

Received: 10/05/18

\(^3\) http://www.nber.org/papers/w24846
Whereas, There is considerable science-based evidence for the benefits of breastfeeding over the use of commercial formulas for both infant and mother; and

Whereas, The rate of breastfeeding of infants under the age of six months around the world is only 40 percent, and

Whereas, The representatives of United States government to the World Health Assembly/World Health Organization vigorously discouraged a resolution by that body to advocate the preference and emphasize the health benefits of breastfeeding; and

Whereas, Mothers who wish to nurse still face some substantial impediments in many states; therefore be it

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 (New HOD Policy); 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. (New HOD Policy)

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

Received: 10/09/18
RELEVANT AMA POLICY

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 breastfeeding; 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.

Citation: CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17
Whereas, It is estimated that 168,082 individuals in Indiana have a severe mental illness (SMI), of which 79,783 are currently untreated; and

Whereas, It is estimated that 2,413 individuals with SMI are in state, private and psychiatric units in general hospitals in Indiana; and

Whereas, It is estimated that 6,393 individuals, or 15 percent of inmates in Indiana jails and prisons, are SMI, making the odds of an SMI person being in jail or prison compared with being treated in a hospital 2.6 to 1; and

Whereas, Corrections Officers (COs) can play a vital role in the proper treatment of offenders with mental illness but generally receive very little training in mental health issues, making violence between inmates and officers commonplace; and

Whereas, The National Alliance on Mental Illness (NAMI) Indiana chapter, in conjunction with the Indiana University School of Medicine Department of Psychiatry, developed a 10-hour education program that taught COs the major categories of psychiatric disorders, the biology and treatment behind mental illness and effective ways to interact with mentally ill inmates, which led to a significant reduction in the use of force by COs and the number of assaults with bodily waste by the offenders; and

Whereas, According to a NAMI volunteer and member of the NAMI-Indiana Board of Directors, the Indiana Department of Correction has embedded this course within its training curriculum for prison COs, but this training is not in place in the majority of Indiana county jails; and

Whereas, Police officers may perceive mental health-related calls as unpredictable and dangerous, which without adequate training in de-escalation could cause them to approach in a manner that inadvertently escalates the situation; and

Whereas, It is estimated that 1 in 4 fatal police encounters ends the life of an individual with SMI, making the risk of being killed during a police incident 16 times greater for individuals with untreated mental illness than for other civilians; and
Whereas, A crisis intervention team (CIT) is an evidence-supported program that improves the way law enforcement responds to individuals experiencing a mental health crisis by (1) building partnerships between local law enforcement agencies, mental health providers and mental health advocates, including but not limited to NAMI-Indiana; (2) providing officers with a 40-hour curriculum consisting of lectures, on-site visitation, interaction with individuals with mental illness and scenario-based de-escalation skill training; and 3) directing individuals with mental illness toward treatment rather than incarceration; and

Whereas, The Fort Wayne Police Department’s CIT reported diverting 99 percent of mental health calls away from jail and into the mental health system in 2012; and

Whereas, Despite evidence showing that CIT improves public safety and significantly decreases the number of arrests and re-arrests of SMI individuals, only 10 of 92 Indiana counties have an active CIT program; and

Whereas, The AMA (1) continues to support jail diversion and community-based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the CIT model programs; and (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; therefore be it

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. (New HOD Policy)

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

Received: 10/09/18

RELEVANT AMA POLICY

https://policysearch.ama-assn.org/policyfinder/search/mental%20illness%20in%20jails/relevant/1/.
Whereas, The AMA has adopted principles that support that information technology available to physicians should support the physician's obligation to put the interests of patients first; and

Whereas, The information technology available to physicians should support the integrity and autonomy of physicians; and

Whereas, The AMA has affirmed a commitment to working with federal and state agencies, policy makers and other relevant stakeholders to improve EHRs; and

Whereas, Dissatisfaction among EHR end-users has contributed to physician burnout, and a diminished patient-physician relationship; and

Whereas, The Centers for Medicaid and Medicare Services (CMS) has determined that the History of Present Illness (HPI) cannot be performed incident to the physician by ancillary employees (ie, RN, LPN, MA or any other individual not able to bill Medicare for physicians’ services); and

Whereas, The “keystroking” of the information contained in the HPI as contained by the EHR is NOT necessarily validation that a face to face visit by the physician was performed; and

Whereas, The “keystroking” of orders signed by a physician is acceptable to CMS and these orders are much more likely to directly result in error; and

Whereas, A physician’s signature and declarative sentences regarding the nature of their work and involvement in the “HPI” portion of patient care should be sufficient to document their involvement in the care of the patient and doing so does not indicate that this information was treated as anything less than preliminary; therefore be it

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 (Directive to Take Action); 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. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 10/05/18
Resolution: 222
(I-18)

Introduced by: Maryland

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

Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

Whereas, There are two types of quality measure reports that are required to be produced by Meaningful Use Stage 2 Certified EHRs: QRDA I reports provide detailed information about patients including names, dates of birth, addresses, race and ethnicity and conditions such as diabetes, drug and alcohol abuse, obesity, depression, etc. and QRDA III reports which are summary reports which do not contain personal information about patients; and

Whereas, Patients do not give permission to submit the personally identified QRDA I reports for either PQRS for Medicare and Medicaid or for Meaningful Use Quality Reporting; and

Whereas, The release of private information without permission can undermine the willingness of patients to confide in their provider and may undermine the provider-patient relationship; and

Whereas, The quality measures include very sensitive information; and

Whereas, There are no guarantees that the database containing this personally identified information can be protected from illegal access; and

Whereas, There are no guarantees that the database will not be released deliberately, by act of law or regulation, sometime in the future, without patient permission; therefore be it

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. (Directive to Take Action)

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

Received: 10/11/18
RELEVANT AMA POLICY

3.1.1 Privacy in Health Care
Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust. Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:
(a) Minimize intrusion on privacy when the patients privacy must be balanced against other factors.
(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

*AMA Principles of Medical Ethics: I,IV*

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

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.

Whereas, Our AMA supports health insurance coverage for all children as a national priority; and

Whereas, The State Children’s Health Insurance Program (SCHIP) provides comprehensive health care insurance to over 8.9 million children and 360,000 pregnant women across the country; and

Whereas, The purpose of SCHIP is to provide health insurance to children from socioeconomically disadvantaged backgrounds; and

Whereas, Children are covered by SCHIP if their parents earn too much for Medicaid but cannot afford private insurance; and

Whereas, The proportion of uninsured children dropped from 15 percent to 9 percent of all children since SCHIP’s establishment in 1997 and the rates of uninsured children within the typical SCHIP family income range fell from 22.8 percent to 6.7 percent from 1997 to 2015; and

Whereas, Children in SCHIP have better access to care, fewer unmet needs, better educational performance, and greater financial protection compared to when they were uninsured; and

Whereas, SCHIP is jointly funded by federal and state governments, and funds are administered individually at the state level; and

Whereas, Federal funding for SCHIP expired on September 30, 2017, because of political arguments unrelated to health care and stable funding was not restored until January 23, 2018; and

Whereas, During the first four months of FY 2018, states operated SCHIP without renewal of federal funding until Congress extended SCHIP with a 6-year extension on January 22, 2018; and

Whereas, Prior to the 6-year extension, 31 states were projected to exhaust SCHIP funds by March 2018 and by the end of fiscal year 2018, all 50 states would have exhausted remaining CHIP funding; and

Whereas, During this lapse in funding, 14 states planned on freezing, phasing out, or terminating coverage for children once their funds ran out, which would have left 611,052 children without health insurance on February 1, 2018; and
Whereas, Seven other states planned to close or cap total enrollment, three planned to decrease or terminate funds for pregnant women, and a handful would have transitioned children from CHIP to Medicaid programs; thereby, increasing state costs through the lower Medicaid reimbursement rate; and

Whereas, During previous state freezes in SCHIP enrollment, affected children went almost entirely without access to health care services and families faced financial hardship; and

Whereas, A permanent extension and reauthorization of SCHIP would prevent these vulnerable populations from going without access to health care and would prevent SCHIP from being inappropriately used in future political arguments; and

Whereas, Long-term funding of SCHIP saves money for state and federal governments, evidenced by the Congressional Budget Office’s official estimates stating that a five-year CHIP extension would cost $800 million but a 10-year extension would save $6 billion; and

Whereas, Despite SCHIP’s current authorization lasting for 10 years, multiple United States Senators have advocated for a permanent reauthorization of CHIP, which would save money for state and federal governments, as well as provide certainty to those governments and the families who need it; therefore be it

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 (Modify Current HOD Policy); 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 (Modify Current HOD Policy); 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. (Directive to Take Action)

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

Received: 10/10/18

RELEVANT AMA POLICY

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.
Citation: (Res. 118, A-07; CMS Rep. 1, A-07; Reaffirmation A-14)

Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976
1. It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs to adult coverage, our American Medical Association urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100% of RBRVS Medicare allowable.
Citation: Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17
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.

Citation: (Res. 117, A-07; Res. 118, A-07; Res. 119, A-07; Reaffirmation A-14)

Protecting Children, Adolescents and Young Adults in Medicaid and the State Children’s Health Insurance (SCHIP) Program D-290.985

Our AMA will actively: (1) encourage state and county medical societies to advocate for initiatives to ensure that all eligible children, adolescents, and young adults are enrolled in Medicaid and SCHIP; (2) advocate for federal and state funding for Medicaid and SCHIP so that funding is sufficient to support enrollment of and provision of necessary services to all eligible children, adolescents, and young adults; and (3) encourage state and county medical societies to work to ensure that services to children, adolescents, and young adults meet Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Standards.

Citation: (Res. 108, A-06; Reaffirmation A-14)

SOURCES
15. Summary of 2018 CHIP Funding Extension.
18. When Will CHIP Funding Run Out? Georgetown University Health Policy Institute: Center for Children and Families.
Whereas, The Center for Medicare & Medicaid has authorized quality improvement organizations (QIO) to review medical services provided to Medicare patients; and

Whereas, The QIOs perform reviews of healthcare provided to Medicare patients to determine if the care meets professionally recognized standards of care; and

Whereas, QIOs conduct these reviews to investigate complaints initiated by beneficiaries or the patients’ representatives about the health care they received; and

Whereas, The QIO peer reviewer is stated to be either a physician or other practitioner who matches, as closely as possible, the variables of licensure, specialty, and practice setting of the physician or practitioner under review; and

Whereas, When the QIO peer reviewer has no peer match available, the QIO may use another physician reviewer without the same expertise; and

Whereas, The practitioner should be made aware when a reviewer is outside their area of expertise; and

Whereas, The QIO should report annually on the number of peer reviews where the reviewer was outside the reviewer’s area of expertise; and

Whereas, If, after reviewing the Peer Review, the QIO determines that the Peer Reviewer has identified a concern(s) for which the standard(s) of care was not met, the practitioner and/or provider must be offered the opportunity to discuss the concern(s); and

Whereas, In instances when the practitioner and/or provider requests to submit new and/or additional medical information, the QIO advises the practitioner and/or provider of his/her right to request a reconsideration and that any new and/or additional medical information can be considered during the reconsideration process; and

Whereas, Reconsideration is the additional review performed by the QIO when requested by the beneficiary and/or the practitioner/provider when any of the parties is not pleased with the outcome of the QIO’s Initial Determination; and

Whereas, If a reconsideration review is undertaken, that constitutes the QIO final decision and there are no further appeal rights available; and
Whereas, The only opportunity for the provider to respond is after the initial review and if the initial review finds no quality of care concern, the practitioner has no reason to respond; and

Whereas, If the beneficiary requests a reconsideration review and the finding is different from the initial finding, there is no recourse for the practitioner to respond; and

Whereas, If the second review has a quality of care concern identified, it is entered into the CMS database and if the QIO feels the issue may have significance beyond a single episode, a determination may be made that further intervention activities are required; and

Whereas, The CMS manual states that “In the rare instance when a Reconsideration Peer Reviewer identifies a new concern, the Reviewer must notify the QIO for the QIO to initiate processing of the newly identified concern at the Quality of Care Review Stage. The Reconsideration Peer Reviewer must not evaluate the concern because the matter will be eligible for review by an Initial Determination Peer Reviewer”; and

Whereas, QIOs are not interpreting this to allow for a new review in cases where the initial peer review found no quality of care issue; and

Whereas, CMS states that the Peer review is intended to be a collegial interaction with the goal of improving patient care; and

Whereas, The CMS QIO manual states that it is a “basic premise of fairness that beneficiaries, practitioners and/or providers are notified of the ability to file a request for reconsideration”; and

Whereas, By extension it is a basic premise of fairness that a practitioner should be able to defend an allegation of a deviation from a standard of care; and

Whereas, QIOs purport that their primary purpose is to identify areas where health care services can be improved and provide feedback to facilities and practitioners; and

Whereas, The QIOs state that the Peer review is intended to be a collegial interaction with the goal of improving patient care; therefore, be it

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 (Directive to Take Action); 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 (Directive to Take Action); 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. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 10/09/18

Reference:
Whereas, Legislation is under consideration in the United State Senate to create new rules for payment of “surprise” out of network bills for patients treated in hospitals; and

Whereas, Components of this draft legislation would call for health insurers to pay for out of network “surprise” bills as a percentage of in-network rates; and

Whereas, These “surprise” out of network bills are often the result of health insurers creating narrow networks that limit patient choice and dis-incentivize physician participation; and

Whereas, Failure to ensure fair payment for out of network emergency care could have an enormously adverse impact on the ability of hospitals to assure necessary availability of on-call specialty physician care to meet patient need; and

Whereas, Several states across the country have enacted laws that provide patients protection against these “surprise” bills; and

Whereas, The AMA has adopted policy H-285.904, “Out-of-Network Care,” that includes a component that “Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties”; and

Whereas, AMA Policy H-285.904 also states that “Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company”; and

Whereas, AMA policy H-285.904 also states, with regard to “unanticipated” out of network services, that “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”; and

Whereas, Current AMA policy does not expressly call for the AMA to advocate for federal legislation consistent with these principles; and
Whereas, Current federal legislation does not address health insurer network adequacy problems; and

Whereas, Federal legislation has the potential to pre-empt state laws that have been shown to address these problems in ways that are fair to patients, health insurers, hospitals and physicians; and

Whereas, Even if such federal legislation were to not pre-empt state law, it has the potential to create new standards that states with existing “surprise” bill laws may seek to match; therefore be it

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 (New HOD Policy); 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. (New HOD Policy)

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

Received: 10/10/18

RELEVANT AMA POLICY

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 physician's 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
Whereas, As of 2016 78% of physicians and 96% of hospitals routinely use electronic health records (EHRs) during care, and nationally only half of hospitals have necessary patient information electronically available from providers or sources outside their systems at the point of care; and

Whereas, Accessing patient data through a health information exchange (HIE) in an emergency department has been shown to reduce hospital admissions, and decrease unneeded diagnostic imaging and procedures; and

Whereas, An HIE increases provider access to data necessary for treatment such as results of tests conducted in another health care practice while lack of exchange may result in duplicate and unnecessary testing; and

Whereas, An HIE has been shown to reduce net annual costs for patient care, even after accounting for costs related to the HIE, and cost reductions are seen in healthcare markets that have operational HIEs caring for Medicare patients; and

Whereas, Clinicians across the country need ready access to data from clinical settings outside their own to deliver cost effective, non-duplicative care for their patients; and to be competitive in new payment arrangements that incentivize coordinated care, reduction in unneeded testing and imaging, and a view of the health of their patient in and outside of the clinical setting; therefore be it

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. (Directive to Take Action)

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

Received: 10/11/18
References

Whereas, Our AMA and the state and specialty medical societies of the AMA federation are committed to working with the Centers for Medicare and Medicaid Services (CMS) to reduce provider burden and increase Medicare beneficiaries’ access to appropriate care; and

Whereas, CMS is to be commended for recognizing the problems with the current evaluation and management documentation guidelines and codes, and for including a significant proposal to address them in the CY 2019 Medicare physician fee schedule proposed rule; and

Whereas, CMS in its physician fee schedule proposed rule put forward a plan to cut and consolidate evaluation and management services, which would severely reduce Medicare patients’ access to care by cutting payments for complex office visits, adversely affecting the care and treatment of patients with complex conditions; and

Whereas, The proposals to consolidate the billing codes for physician evaluation and management so as to pay the same amount for office visits regardless of the complexity of the patient would cut payments for visits that are currently reimbursed at higher levels than simple or routine office visits, penalizing doctors who treat sicker or complex patients, or patients with multiple conditions; and

Whereas, Payments from newly proposed add-on codes, which have been put forward with the intention of protecting complex care by making up for severe cuts, are not certain and likely would not be sufficient to ensure continued patient access, and moreover the application of new codes to some specialties and not others would effectively result in CMS picking winners and losers; and

Whereas, We agree with CMS’ ultimate goal of increasing the amount of time physicians have to spend with patients instead of paperwork and computers, but the collapsing of evaluation and management codes would have an immediate and lasting effect of restricting patient access to care; and
Whereas, CMS is expected to release the CY 2019 physician fee schedule final rule in November of 2018, less than two months ahead of the proposed implementation date of January 1, 2019; and

Whereas, Given the negative impacts of this well-intentioned proposal, CMS should not finalize these concepts as proposed; and

Whereas, The physician community stands ready to work with CMS to identify alternative approaches that would accomplish its goal of reducing paperwork and administrative burden without endangering patient access to care, and while ensuring that physicians have the resources they need to provide patients with the high-quality care they deserve; therefore be it

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. (Directive to Take Action)

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

Received: 10/11/18

RELEVANT AMA POLICY

Medicare Guidelines for Evaluation and Management Codes H-70.952
Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) will facilitate review and corrective action regarding the excessive content of the evaluation and management documentation guidelines in collaboration with the national medical specialty societies and to work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies affected by such guidelines; (6) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; (7) urges CMS to establish a test period in a specific geographic region for these new guidelines to determine any effect their implementation will have on quality patient care, cost effectiveness and efficiency of delivery prior to enforcement of these mandated regulations; (8) opposes adoption of the Medicare evaluation and management documentation guidelines for inclusion in the CPT; and (9) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.
Citation: (Sub. Res. 801, I-97; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

Preservation of Evaluation/Management CPT Codes H-70.985
It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services; (2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes; (3) seek feedback from its members on insurance practices that advocate bundling of procedures and
laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members; (4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and (5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.

Citation: (Sub. Res. 98, A-90; Reaffirmed by Res. 850, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

**Preservation of Five Levels of Evaluation and Management Services D-70.979**

Our AMA will communicate to the Centers for Medicare and Medicaid Services and to private payers that the current levels of Evaluation and Management services should be maintained and not compressed, with appropriate payment for each level.

Citation: Sub. Res. 804, I-01; Reaffirmation A-06; Reaffirmed in lieu of Res. 823, I-06; Modified: CMS Rep. 01, A-16