

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(I-18)

Introduced by: GLMA: Health Professionals Advancing LGBTQ Equality; New York;
Minority Affairs Section; Medical Student Section

Subject: Affirming the Medical Spectrum of Gender

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

-
- 1 Whereas, The current US population of transgender adults is estimated to be about 390 per
2 100,000 people, or about 1 million adults¹; and
3
4 Whereas, The current US population of people with differences in sexual differentiation is
5 difficult to accurately calculate due to the variety of etiologies, with some estimates ranging from
6 0.05-1.7%²⁻⁴; and
7
8 Whereas, Our AMA believes that the physician's nonjudgmental recognition of patients' gender
9 identities enhances the ability to render optimal patient care (H-160.991); and
10
11 Whereas, Sex and gender are complex and fluid parts of individuals' identities that may not
12 align with the sex assigned to them at birth⁵; and
13
14 Whereas, Having a sex or gender identity that differs from that assigned at birth determines
15 certain healthcare decisions and modes of treatment, including hormone replacement therapy,
16 gender-affirming surgery, and HIV prevention interventions⁶; and
17
18 Whereas, Our AMA has existing policy directing the organization to "work with appropriate
19 medical organizations and community based organizations to inform and educate the medical
20 community and the public on the medical spectrum of gender identity" (D-295.312); and
21
22 Whereas, Persons who identify as transgender are recognized by professional organizations
23 such as the American Psychiatric Association, the American Medical Association, and the
24 American Academy of Family Physicians with each organization having issued statements that
25 emphasize the importance of transgender health; and
26
27 Whereas, Data has shown that there may be a connection between policies that protect people
28 who are transgender and better mental health in these persons including significantly lower
29 reports of mood disorders and self-harm; and
30
31 Whereas, Pursuant to existing AMA policy H-65.965 and H-65.964, our AMA opposes
32 discrimination on the basis of gender identity and specifically advocates for "policies that
33 promote social equality and safe access to basic human services and public facilities for
34 transgender individuals according to one's gender identity"; therefore be it

1 RESOLVED, That our American Medical Association amend HOD Policy D-295.312, "Medical
2 Spectrum of Gender," by addition to read as follows:

3
4 Medical Spectrum of Gender D-295.312

5
6 Given the medical spectrum of gender identity and sex, Our AMA:

7
8 (1) Will work with appropriate medical organizations and community based
9 organizations to inform and educate the medical community and the public on the
10 medical spectrum of gender identity;

11
12 (2) Will educate state and federal policymakers and legislators on and advocate for
13 policies addressing the medical spectrum of gender identity to ensure access to
14 quality health care; and

15
16 (3) Affirms that an individual's genotypic sex, phenotypic sex, sexual orientation,
17 gender and gender identity are not always aligned or indicative of the other, and that
18 gender for many individuals may differ from the sex assigned at birth. (Modify
19 Current HOD Policy); and be it further

20
21 RESOLVED, That our AMA oppose any effort to prohibit the reassignment of an individual's
22 sex. (New HOD Policy)

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

Received: 10/31/18

References:

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5227946/> *Transgender Population Size in the United States: a Meta-Regression of Population-Based Probability Samples*

² <https://www.ncbi.nlm.nih.gov/pubmed/12476264> *How common is intersex?;*

³ <https://www.intersexequality.com/how-common-is-intersex-in-humans;>

⁴ <http://www.isna.org/faq/frequency>

⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4062023/> *Sex and Gender in the US Health Surveillance System: A Call to Action*

⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4969060/> *Integrated and Gender-Affirming Transgender Clinical Care and Research*

RELEVANT AMA POLICY

Medical Spectrum of Gender D-295.312

Our AMA will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity.

Citation: Res. 003, A-17

Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients H-65.967

1. Our AMA supports policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care.

2. Our AMA: (a) supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth

certificates; and (b) supports that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventive care.

Citation: (Res. 4, A-13; Appended: BOT Rep. 26, A-14)

Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961

Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates.

Citation: (CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12)

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Citation: (Res. 402, A-12)

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-

date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17

Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.

Citation: Res. 010, A-17

Appropriate Placement of Transgender Prisoners H-430.982

1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoners genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.

2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Citation: BOT Rep. 24, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002
(I-18)

Introduced by: American Academy of Hospice and Palliative Medicine; American Academy of Pain Medicine; American College of Rheumatology; American Society of Addiction Medicine; American Society of Anesthesiologists; American Society of Clinical Oncology; American Society of Interventional Pain Physicians; North American Neuromodulation Society; Spine Intervention Society; Frank G. Dowling, MD, Delegate

Subject: Inappropriate Use of CDC Guidelines for Prescribing Opioids

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

1 Whereas, In response to the epidemic of opioid diversion, misuse, addiction, overdoses, and
2 overdose deaths, the federal Centers for Disease Control and Prevention issued the CDC
3 Guidelines on Opioid Prescribing; and
4

5 Whereas, This document was intended as a guide to improved medical practice and to serve as
6 a tool for prevention, and was not intended as a standard of practice or a directive on mandating
7 clinical decisions, and was specifically designed to address opioid prescribing outside of cancer
8 care or end-of-life care; and
9

10 Whereas, There is concern in some quarters that the CDC Guidelines can assist in reducing
11 excessive prescribing of opioids for persons not already on opioids but do not clearly provide
12 guidance on the management of patients who have already on high dose opioid therapy chronic
13 non-malignant pain who may be “inherited” by a practitioner from another practitioner and have
14 been referred to as “legacy patients”; and
15

16 Whereas, The CDC Guidelines appropriately suggest non-opioid alternatives to be utilized
17 before the initiation of opioid therapy and also mention levels of opioid prescribing such as
18 Morphine Milligram Equivalents (MMEs) above which there is a demonstrated correlation with
19 adverse clinical scenarios; and
20

21 Whereas, Some licensure boards have taken the approach that a licensed health professional
22 with prescribing privileges is practicing below the community standard for quality care if they
23 prescribe opioids in excess of the MME levels mentioned in the CDC Guidelines; and
24

25 Whereas, Some legislatures have taken actions to criminalize certain medical practices to the
26 extent that a physician may be liable for criminal prosecution if he/she were to prescribe opioids
27 in amounts that exceed the MME levels mentioned in the CDC Guidelines; and
28

29 Whereas, Upon discovering that any physician who prescribes methadone or buprenorphine
30 products for the treatment of addiction involving opioid use are going to be prescribing MMEs
31 that exceed then threshold levels mentioned in the CDC Guidelines, the American Society of
32 Addiction Medicine wisely crafted a Public Policy Statement saying that buprenorphine and
33 methadone doses for the maintenance treatment of addiction should not be “counted” as a

1 “violation” of the MME equivalents of the CDC Guidelines or of other practice edicts or state
2 statutes; and

3
4 Whereas, Some national pharmacy chains have recently generated letters to physicians
5 informing them that they plan to scrutinize incoming prescriptions and at times will not fill a
6 prescription that calls for an opioid dosage that exceeds the CDC Guidelines; and

7
8 Whereas, Such decisions by pharmacies or pharmacists can interfere with the practice of
9 medicine and interfere with good quality patient care by a pain medicine physician, oncologist,
10 or palliative care physician when the pharmacy refuses to fill a legally written prescription; and

11
12 Whereas, The CDC Guidelines should be utilized as informational and should not be misused
13 as standards of care; therefore be it

14
15 RESOLVED, That our American Medical Association applaud the Centers for Disease Control
16 and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse,
17 addiction, and overdose deaths; and be it further

18
19 RESOLVED, That no entity should use MME (morphine milligram equivalents) thresholds as
20 anything more than guidance and that MME thresholds should not be used to completely
21 prohibit the prescribing of, or the filling of prescriptions for, medications used in oncology care,
22 palliative medicine care, and addiction medicine care (New HOD Policy); and be it further

23
24 RESOLVED, That our AMA communicate with the nation’s largest pharmacy chains and
25 pharmacy benefit managers to recommend that they cease and desist with writing threatening
26 letters to physicians and cease and desist with presenting policies, procedures and directives to
27 retail pharmacists that include a blanket proscription against filling prescriptions for opioids that
28 exceed certain numerical thresholds without taking into account the diagnosis and previous
29 response to treatment for a patient and any clinical nuances that would support such prescribing
30 as falling within standards of good quality patient care (New HOD Policy); and be it further

31
32 RESOLVED, That AMA Policy opposing the legislating of numerical limits on medication
33 dosage, duration of therapy, numbers of pills/tablets, etc., be reaffirmed (Reaffirm HOD Policy);
34 and be it further

35
36 RESOLVED, That physicians should not be subject to professional discipline or loss of board
37 certification or loss of clinical privileges simply for prescribing opioids at a quantitative level that
38 exceeds the MME thresholds found in the CDC Guidelines (New HOD Policy); and be it further

39
40 RESOLVED, That our AMA encourage the Federation of State Medical Boards and its member
41 boards, medical specialty societies, and other entities (including, possibly, the CDC) to develop
42 improved guidance on management of pain and management of potential withdrawal
43 syndromes and other aspects of patient care for “legacy patients” who may have been treated
44 for extended periods of time with high-dose opioid therapy for chronic non-malignant pain. (New
45 HOD Policy)

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

Received: 11/09/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1003
(I-18)

Introduced by: American Thoracic Society, Society of Critical Care Medicine, American College of Chest Physicians

Subject: Oppose FDA's Decision to Approve Primatene Mist HFA for Over the Counter Use

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

- 1 Whereas, 25 million Americans have physician diagnosed asthma; and
2
3 Whereas, Even patients with mild asthma can suffer life threatening asthma exacerbations; and
4
5 Whereas, Existing prescription drugs for asthma reduce symptoms, prevent exacerbations and
6 provide relief to patients experiencing an asthma exacerbation; and
7
8 Whereas, On November 07, 2018, FDA announced it has approved inhaled epinephrine
9 (Primatene Mist HFA) for over the counter use for the treatment of mild and intermittent asthma;
10 and
11
12 Whereas, The use of inhaled epinephrine is not recommended or indicated in the treatment of
13 asthma by both international and national clinical practice guidelines, including the Global
14 Initiative for Asthma, and particularly the NIH National Asthma Education Prevention Program
15 guidelines which states that:
16
17 "The less beta2-selective agents (isoproterenol, metaproterenol, isoetharine, and
18 epinephrine) are not recommended due to their potential for excessive cardiac
19 stimulation, especially in high doses." ; and
20
21 Whereas, In 2011, the FDA removed inhaled epinephrine from the US market (due to its use of
22 an ozone depleting propellant); and
23
24 Whereas, In 2014 the FDA held a joint public meeting organized by the Over-the-counter Drug
25 Division and the Pulmonary and Allergy Drug Advisory Committees to hear public comment on
26 whether to approve the inhaled epinephrine new drug application; and
27
28 Whereas, In 2014 the FDA did not approve new drug application for inhaled epinephrine; and
29
30 Whereas, In FDA's deliberation in 2018 about whether to approve inhaled epinephrine, the FDA
31 did not hold public meetings to collect public input nor publish a federal register notice to solicit
32 public input; therefore be it

1 RESOLVED, That our American Medical Association send a letter to the US Food and Drug
2 Administration (FDA) expressing: 1) our strong opposition to FDA making the decision to allow
3 inhaled epinephrine to be sold as an over-the counter medication without first soliciting public
4 input, and 2) our opposition to the approval of over-the-counter sale of inhaled epinephrine as it
5 is currently not a recommended treatment for asthma. (Directive to Take Action)

Fiscal Note: Moderate: Between \$5,000 - \$10,000.

Received: 11/10/18

REFERRAL CHANGES AND OTHER REVISIONS (I-18)

REVISED RESOLUTIONS AND REPORTS

- CEJA Opinion 03 - Mergers of Secular and Religiously Affiliated Health Care Institutions - CORRECTED (Notice given in the Handbook Addendum)
- Report of the HOD Committee on Compensation of the Officers (REVISED)
- 202 - Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings (REVISED)
- 218 - Alternatives to Tort for Medical Liability (REVISED)
- 804 – Arbitrary Documentation Requirements for Outpatient Services (REVISED)

WITHDRAWN RESOLUTIONS

- 227 - CMS Proposal to Consolidate Evaluation and Management Services
- 811 - Infertility Benefits for Active-Duty Military Personnel
- 962 - Improve Physician Health Programs

OTHER REVISIONS

- Resolution 802 - Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk) (Fiscal note increased from \$30,000 to \$100,000)
- Resolution 812 – ICD Code for Patient Harm from Payer Interference (Change in sponsorship from ~~Craig A. Backs, MD, Delegate~~ to Illinois)

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- 201 - Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application (Virginia, American Association of Clinical Urologists, Georgia, American Urological Association, American College of Radiology)
- 217 - Opposition to Medicare Part B to Part D Changes (American Society of Clinical Oncology, American College of Rheumatology, American Gastroenterological Association)
- 810 - Medicare Advantage Step Therapy (American Society of Clinical Oncology, American College of Rheumatology, American Gastroenterological Association)

* Additional sponsors underlined.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials

Presented by: David T. Walsworth, MD, Chair
Sunday, November 11, 2018

1 Madam Speaker, Members of the House of Delegates:

2
3 (1) LATE RESOLUTION(S)

4
5 The Committee on Rules and Credentials met Saturday, November 10, to discuss Late
6 Resolution(s) 1001 – 1003. Sponsors of the late resolutions met with the committee to consider
7 late resolutions, and were given the opportunity to present for the committee's consideration the
8 reason the resolution could not be submitted in a timely fashion and the urgency of
9 consideration by the House of Delegates at this meeting.

10
11 Recommended for acceptance:

- 12
13 • Late 1001 - Affirming the Medical Spectrum of Gender
14 • Late 1002 - Inappropriate Use of CDC Guidelines for Prescribing Opioids
15 • Late 1003 - Oppose FDA's Decision to Approve Primatene Mist HFA for Over the
16 Counter Use

17
18 (2) REAFFIRMATION RESOLUTIONS

19
20 The Speakers asked the Committee on Rules and Credentials to review the recommendations
21 for placing resolutions introduced at this meeting of the House of Delegates on the
22 Reaffirmation Calendar. Reaffirmation of existing policy means that the policies reaffirmed
23 remain active policies within the AMA policy database and therefore are part of the body of
24 policy that can be used in setting the AMA's agenda. It also resets the sunset clock, so such
25 policies will remain viable for 10 years from the date of reaffirmation. The Committee
26 recommends that current policy be reaffirmed in lieu of the following resolutions (current policy
27 and AMA activities are listed in the Appendix to this report):

- 28
29 • Resolution 201 – Reimbursement for Services Rendered During Pendency of
30 Physician's Credentialing Application
31 • Resolution 203 – Support for the Development and Distribution of HIPAA-Compliant
32 Communication Technologies
33 • Resolution 207 – Defense of Affirmative Action
34 • Resolution 208 – Increasing Access to Broadband Internet to Reduce Health Disparities
35 • Resolution 213 – Increasing Firearm Safety to Prevent Accidental Child Deaths
36 • Resolution 214 – A Public Health Case for Firearm Regulation
37 • Resolution 218 – Alternatives to Tort for Medical Liability
38 • Resolution 219 – Promotion and Education of Breastfeeding
39 • Resolution 221 – Regulatory Relief from Burdensome CMS "HPI" EHR Requirements
40 • Resolution 222 – Patient Privacy Invasion by the Submission of Fully Identified Quality
41 Measure Data to CMS
42 • Resolution 223 – Permanent Reauthorization of the State Children's Health Insurance
43 Program
44 • Resolution 224 – Fairness in the Centers for Medicare & Medicaid Services Authorized
45 Quality Improvement Organization's (QIO) Medical Care Review Process
46 • Resolution 226 – Support for Interoperability of Clinical Data

- 1 • Resolution 228 – Medication Assisted Treatment
- 2 • Resolution 806 – Telemedicine Models and Access to Care in Post-Acute and Long-
- 3 Term Care
- 4 • Resolution 808 – The Improper Use of Beers or Similar Criteria and Third-Party Payer
- 5 Compliance Activities
- 6 • Resolution 809 – Medicaid Clinical Trials Coverage
- 7 • Resolution 810 – Medicare Advantage Step Therapy
- 8 • Resolution 813 – Direct Primary Care Health Savings Account Clarification
- 9 • Resolution 814 – Prior Authorization Relief in Medicare Advantage Plans
- 10 • Resolution 815 – Uncompensated Physician Labor
- 11 • Resolution 816 – Medicare Advantage Plan Inadequacies
- 12 • Resolution 817 – Increase Reimbursement for Psychiatric Services
- 13 • Resolution 818 – Drug Pricing Transparency
- 14 • Resolution 819 – Medicare Reimbursement Formula for Oncologists Administering
- 15 Drugs
- 16 • Resolution 821 – Direct Primary Care and Concierge Medicine Based Practices
- 17 • Resolution 920 – Continued Support for Federal Vaccination Funding
- 18 • Resolution 922 – Full Information on Generic Drugs
- 19 • Resolution 923 – Scoring of Medication Pills
- 20 • Resolution 924 – Utilizing Blood from Therapeutic Donations
- 21 • Resolution 956 – Increasing Rural Rotations During Residency
- 22 • Resolution 958 – National Health Service Corps Eligibility

Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Barbara J. Arnold, MD, Rebecca Brendel, MD, Ralph J. Nobo, MD, Kevin C. Reilly, Sr., MD, and Colette R. Willins, MD, and on behalf of the committee those who appeared before the committee.

Barbara J. Arnold, MD
California

Kevin C. Reilly, Sr., MD
Radiological Society of North America

Rebecca Brendel, MD
American Psychiatric Association

Colette R. Willins, MD
American Academy of Family Physicians

Ralph J. Nobo, Jr., MD
Florida

David T. Walsworth, MD, Chair
Michigan

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

- Resolution 201 – Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application
 - Physician Privileges Application – Timely Review by Managed Care H-180.956
 - Physician Privileges Application – Timely Review by Managed Care D-180.995
- Resolution 203 – Support for the Development and Distribution of HIPAA-Compliant Communication Technologies
 - Guidelines for Patient-Physician Electronic Mail and Text Messaging H-478.997
 - Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging D-478.970
- Resolution 207 – Defense of Affirmative Action
 - Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979
 - Strategies for Enhancing Diversity in the Physician Workforce D-200.985
 - Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917
- Resolution 208 – Increasing Access to Broadband Internet to Reduce Health Disparities
 - Improving Rural Health Care H-465.994
- Resolution 213 – Increasing Firearm Safety to Prevent Accidental Child Deaths
 - Prevention of Unintentional Shooting Deaths Among Children H-145.979
 - Prevention of Firearm Accidents in Children H-145.990
 - Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
 - Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
 - Firearm Safety Counseling in Physician-led Health Care Teams H-145.976
- Resolution 214 – A Public Health Case for Firearm Regulation
 - Gun Violence as a Public Health Crisis D-145.995
 - Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
 - Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
 - Gun Regulation H-145.999
 - Prevention of Firearm Accidents in Children H-145.990
 - Waiting Periods for Firearm Purchases H-145.991
 - Firearm Availability H-145.996
- Resolution 218 – Alternatives to Tort for Medical Liability
 - AMA Support for State Medical Societies' Efforts to Implement MICRA-Type Legislation H-435.943
 - Tort Liability Reform H-435.993
 - Federal Medical Liability Reform H-435.978
 - Health System and Litigation Reform D-435.974
 - Liability Reform D-435.992

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

- Resolution 219 – Promotion and Education of Breastfeeding
 - AMA Support for Breastfeeding H-245.982
- Resolution 221 – Regulatory Relief from Burdensome CMS "HPI" EHR Requirements
 - Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record H-225.965
 - Hospital Admission Histories and Physicals H-215.995
 - Face-to-Face Encounter Rule D-330.914
- Resolution 222 – Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS
 - Patient Privacy and Confidentiality H-315.983
 - Medical Information and Its Uses H-406.987
- Resolution 223 – Permanent Reauthorization of the State Children’s Health Insurance Program
 - Expanding Enrollment for the State Children's Health Insurance Program (SCHIP) H-290.971
 - State Children's Health Insurance Program Reauthorization (SCHIP) D-290.982
- Resolution 224 – Fairness in the Centers for Medicare & Medicaid Services Authorized Quality Improvement Organization’s (QIO) Medical Care Review Process
 - Reduced Physician Role in Governance of Federally Contracted Quality Improvement Organizations H-375.963
 - Quality Improvement Organization Program Status H-340.900
 - Quality Improvement Organization Program Status H-340.901
 - Quality Improvement Organization Program Status H-340.910
 - Quality Improvement Organization Physician Advisory Confidentiality H-340.928
 - Publication in Federal Register of Proposed Changes in QIO Review Process or Procedures H-340.917
 - Additionally, AMA submitted to CMS a letter in October advocating for similar due process procedures for physicians and patients, allowing for physician-to-physician conversations at the second level of review, notifying physicians when a peer reviewer does not have similar expertise or specialty as the physician subject to the QIO process, and to disclose the number of peer reviews performed by reviewers without the same expertise.
- Resolution 226 – Support for Interoperability of Clinical Data
 - EHR Interoperability D-478.972
 - Information Technology Standards and Costs D-478.996
 - Principles for Hospital Sponsored Electronic Health Records D-478.973
 - Health Information Technology Principles H-478.981
- Resolution 228 – Medication Assisted Treatment
 - Workforce and Coverage for Pain Management H-185.931
 - Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944
 - Promotion of Better Pain Care D-160.981

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

- Resolution 806 – Telemedicine Models and Access to Care in Post-Acute and Long-Term Care
 - Coverage of and Payment for Telemedicine H-480.946
- Resolution 808 – The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities
 - Beers or Similar Criteria and Third Party Payer Compliances Activities H-185.940
 - In addition, the Beers Criteria is no longer part of Medicare Star ratings. Rather, effective in 2017, it is simply a “display measure.” Moreover, while the American Geriatric Society states that the criteria be used as both an educational tool and quality measure, it further states that the intent is not to apply the criteria in a punitive manner (see <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2017-Star-Ratings-Request-for-Comments.pdf>).
- Resolution 809 – Medicaid Clinical Trials Coverage
 - Viability of Clinical Research Coverages and Reimbursement H-460.965
 - Based on this policy, the AMA supports H.R. 6836, which promotes access to life-saving therapies for Medicaid enrollees by ensuring coverage of routine patient costs for items and services furnished in connection with participation in qualifying clinical trials (see <https://www.congress.gov/115/bills/hr6836/BILLS-115hr6836ih.pdf>).
- Resolution 810 – Medicare Advantage Step Therapy
 - Opposition to the CMS Medicare Part B Drug Payment Model D-330.904
 - Clinical Practice Guidelines and Clinical Quality Improvement Activities H-320.949
 - Emerging Trends in Utilization Management H-320.958
 - Prescription Drug Plans and Patient Access D-330.910
 - In addition, the AMA and 93 state medical associations and national medical specialty societies raised extensive concerns with CMS in a sign-on letter regarding its new policy allowing Medicare Advantage (MA) plans, starting in 2019, to utilize step-therapy protocols for physician-administered drugs covered under Medicare Part B.
- Resolution 813 – Direct Primary Care Health Savings Account Clarification
 - Direct Primary Care H-385.912
 - The Role of Cash Payments in All Physician Practices H-380.984
 - In addition, the AMA submitted letters in support of legislation referenced in Resolution 813: H.R.6317, the Primary Care Enhancement Act of 2018; and H.R. 365, the Primary Care Enhancement Act of 2017.
- Resolution 814 – Prior Authorization Relief in Medicare Advantage Plans
 - Prior Authorization and Utilization Management Reform H-320.939
 - Preauthorization for Payment of Services H-320.961
 - Approaches to Increase Payer Accountability H-320.968
 - Managed Care Cost Containment Involving Prescription Drugs H-285.965
 - Administrative Simplification in the Physician Practice D-190.974
 - External Grievance Review Procedures H-320.952

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

- In addition, the AMA has been very active in advocating for a reduction in both the number of physicians subjected to prior authorization (PA) and the overall volume of PA. The AMA and a coalition of state and specialty medical societies, national provider associations, and patient organizations developed and released 21 Prior Authorization and Utilization Management Reform Principles that are best practices for prior authorization and other utilization management requirements. The Principles apply to advocacy across all entities that perform utilization management, including Medicaid. A Consensus Statement on Improving the Prior Authorization Process—created by the AMA, American Hospital Association (AHA), America’s Health Insurance Plans (AHIP), American Pharmacists Association (APhA), BlueCross BlueShield Association (BCBSA) and Medical Group Management Association (MGMA)—and model state legislation, “Ensuring Transparency in Prior Authorization Act,” also address the processes outlined in Resolution 814.
- Resolution 815 – Uncompensated Physician Labor
 - Reimbursement for Telephonic and Electronic Communications H-390.859
 - Payment for Electronic Communication H-385.919
- Resolution 816 – Medicare Advantage Plan Inadequacies
 - Medicare Advantage Policies H-330.878
 - Medicare Advantage Policies H-285.913
 - Medicare Advantage Plans D-330.923
 - Medicare Cost-Sharing D-330.951
 - Standardization of Advance Beneficiary Notification of Non-Coverage Forms for Medicare Advantage Plans and Original Fee-For-Service Medicare D-70.950
 - Financing of Long-Term Services and Supports H-280.945
 - Endorse Medicare Part D Educational Website D-330.912
- Resolution 817 – Increase Reimbursement for Psychiatric Services
 - Access to Psychiatric Beds and Impact on Emergency Medicine H-345.978
 - Use of CPT Editorial Panel Process H-70.919
 - Access to Mental Health Services H-345.981
 - Fifty Percent Copayment Requirement for Codes 290-310 Mental Disorders H-345.986
 - Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983
- Resolution 818 – Drug Pricing Transparency
 - Pharmaceutical Costs H-110.987
 - Insulin Affordability H-110.984
 - Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
 - Price of Medicine H-110.991
 - In addition, the AMA in its advocacy and grassroots efforts is taking steps to address the rising cost of prescription drugs in order to improve access, lower costs, and reduce the administrative burdens without stifling innovation. Through its legislative and regulatory efforts on the federal level, development and dissemination of model state legislation and working with interested state medical societies, the AMA is supporting requiring pharmaceutical supply chain transparency – among pharmaceutical manufacturers, pharmacy benefit managers and health plans. In particular, the AMA submitted the a

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

letter to the Honorable Alex M. Azar regarding the Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs, which highlighted its policy priorities addressing drug price transparency and promoting and ensuring fair competition in the pharmaceutical marketplace. Also, the AMA has been active in testifying before Congress on the issue, as evidenced in the Statement of Record on Soaring Prescription Drug Prices: A Bitter Pill to Swallow. The AMA submitted feedback on Congressional efforts to increase health care price and information transparency, including for prescription drugs, to a bipartisan group of Senators. Moreover, the AMA submitted letters in support of H.R. 6733, Know the Cost Act of 2018; S. 2554, The Patients Right to Know Drug Prices Act of 2018; and a bipartisan amendment to require pharmaceutical manufacturers to provide an appropriate disclosure of pricing information for their product in direct-to-consumer (DTC) advertisements.

- In addition, the AMA in 2016 launched a grassroots campaign and website, TruthinRx.org, the goal of which was to expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency. To date, over 265,000 individuals have signed a petition to members of Congress in support of greater drug pricing transparency.
- Finally, relevant to the focus of Resolution 818 on diabetic patients and insulin, the Council on Medical Service presented Report 7 at the 2018 Annual Meeting on insulin pricing, which established Policy H-110.984.
- Resolution 819 – Medicare Reimbursement Formula for Oncologists Administering Drugs
 - Cuts in Medicare Outpatient Infusion Services D-330.960
 - Access to In-Office Administered Drugs H-330.884
 - In addition, the AMA continues to advocate for policies that preserve office-based drug administration and reverse the migration of these services from physician offices to more costly sites of service such as hospital outpatient departments. Examples of recent advocacy on Medicare Part B drug payments include a letter to the Honorable Alex M. Azar regarding the Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs, the AMA’s Statement of Record on Soaring Prescription Drug Prices: A Bitter Pill to Swallow, and the AMA’s Statement of Record on Examining the Pharmaceutical Supply Chain.
- Resolution 821 – Direct Primary Care and Concierge Medicine Based Practices
 - Direct Primary Care H-385.912
 - The Role of Cash Payments in All Physician Practices H-380.984
 - In addition, the AMA submitted letters in support of federal legislation that would address the tax code revision highlighted in Resolution 821: H.R.6317, the Primary Care Enhancement Act of 2018; and H.R. 365, the Primary Care Enhancement Act of 2017.
- Resolution 920 – Continued Support for Federal Vaccination Funding
 - Update on Immunizations and Vaccine Purchases H-440.928
 - Financing of Adult Vaccines: Recommendations for Action H-440.860
- Resolution 922 – Full Information on Generic Drugs
 - Generic Medications H-125.981
 - Generic Drugs H-125.984

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

- Resolution 923 – Scoring of Medication Pills
 - Medication Scoring H-115.973
- Resolution 924 – Utilizing Blood from Therapeutic Donations
 - Blood Donor Recruitment D-50.998
- Resolution 956 – Increasing Rural Rotations During Residency
 - Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
 - The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
 - Significant Problem of Access to Health Care in Rural and Urban Underserved Areas H-200.982
 - Improving Rural Health Care H-465.994
- Resolution 958 – National Health Service Corps Eligibility
 - Addressing the Shortage of Child and Adolescent Psychiatrists D-200.978

SUMMARY OF FISCAL NOTES (I-18)

BOT Report(s)

- 01 Data Used to Apportion Delegates: n/a
- 02 Redefining AMA's Position on ACA and Healthcare Reform: Info Report
- 03 2018 AMA Advocacy Efforts: Info Report
- 04 Increased Use of Body-Worn Cameras by Law Enforcement Officers: Modest
- 05 Exclusive State Control of Methadone Clinics: Modest
- 06 Update on TruthinRx Grassroots Campaign: Info Report
- 07 Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs: Minimal
- 08 340B Drug Discount Program: Modest
- 09 Hospital Closures and Physician Credentialing: Modest
- 10 Training Physicians in the Art of Public Forum: \$20,000 for professional fees for external support and capacity to develop tools and resources
- 11 Violence Prevention: Minimal
- 12 Information Regarding Animal-Derived Medications: Minimal
- 13 2019 Strategic Plan: Info Report
- 14 Protection of Physician Freedom of Speech: Minimal
- 15# Specialty Society Representation in the House of Delegates - Five-Year Review: Minimal

CEJA Opinion(s)

- 01 Medical Tourism: Info Report
- 02 Expanded Access to Investigational Therapies: Info Report
- 03* Mergers of Secular and Religiously Affiliated Health Care Institutions - CORRECTED: Info Report

CEJA Report(s)

- 01* Competence, Self-Assessment and Self-Awareness: Minimal
- 02* Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician-Assisted Suicide" and "Aid-in-Dying": None
- 03* Amendment to E-2.2.1, "Pediatric Decision Making": Minimal
- 04* CEJA Role in Implementing H-140.837, "Anti-Harassment Policy": Minimal
- 05* Physicians' Freedom of Speech: Minimal

CLRPD Report(s)

- 01 Women Physicians Section Five-Year Review: Minimal

CME Report(s)

- 01 Competency of Senior Physicians: Minimal
- 02 Review of AMA Educational Offerings: Info Report
- 03 Developing Physician-Led Public Health / Population Health Capacity in Rural Communities: Minimal
- 04 Reconciliation of AMA Policy on Primary Care Workforce: Minimal
- 05* Reconciliation of AMA Policy on Medical Student Debt: Minimal
- 06 Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours: Minimal
- 07 50th Anniversary of the AMA Physicians' Recognition Award and Credit System: Info Report
- 08 Study of Medical Student, Resident and Physician Suicide: Info Report

SUMMARY OF FISCAL NOTES (I-18)

CMS Report(s)

- 01 Prescription Drug Importation for Personal Use: Minimal
- 02 Air Ambulance Regulations and Payments: Minimal
- 03* Sustain Patient-Centered Medical Home Practices: Minimal
- 04 The Site-of-Service Differential: Between \$100,000 - \$200,000

CSAPH Report(s)

- 01* Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals: Minimal
- 02* FDA Expedited Review Programs and Processes: Minimal

HOD Comm on Compensation of the Officers

- 01# Report of the House of Delegates Committee on Compensation of the Officers (REVISED): Maximum annual stipend estimated at \$87,000

Joint Report(s)

- CMS-CSAPH 01* Aligning Clinical and Financial Incentives for High-Value Care: \$6,000

Report of the Speakers

- 01 Recommendations for Policy Reconciliation: Minimal

Resolution(s)

- 001 Support of a National Registry for Advance Directives: Modest
- 002* Protecting the Integrity of Public Health Data Collection: Modest
- 003* Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children: Modest
- 004# Opposing the Detention of Migrant Children: minimal
- 201 Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application: Modest
- 202# Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings - REVISED: Modest
- 203 Support for the Development and Distribution of HIPAA-Compliant Communication Technologies: Minimal
- 204 Restriction on IMG Moonlighting: Modest
- 205 Legalization of the Deferred Action for Legal Childhood Arrival (DALCA): Modest
- 206 Repealing Potential Penalties Associated with MIPS: Modest
- 207 Defense of Affirmative Action: Minimal
- 208 Increasing Access to Broadband Internet to Reduce Health Disparities: Minimal
- 209 Sexual Assault Education and Prevention in Public Schools: Minimal
- 210 Forced Organ Harvesting for Transplantation: Modest
- 211 Eliminating Barriers to Automated External Defibrillator Use: Modest
- 212 Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings: Modest
- 213 Increasing Firearm Safety to Prevent Accidental Child Deaths: Minimal
- 214 A Public Health Case for Firearm Regulation: Minimal
- 215* Extending the Medical Home to Meet Families Wherever They Go: Modest
- 216* Medicare Part B Competitive Acquisition Program (CAP): Modest
- 217* Opposition to Medicare Part B to Part D Changes: Modest
- 218# Alternatives to Tort for Medical Liability - REVISED: Modest

SUMMARY OF FISCAL NOTES (I-18)

Resolution(s)

- 219* Promotion and Education of Breastfeeding: Modest
- 220* Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement: Minimal
- 221* Regulatory Relief from Burdensome CMS "HPI" EHR Requirements: Modest
- 222* Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS: Modest
- 223* Permanent Reauthorization of the State Children's Health Insurance Program: Modest
- 224* Fairness in the Centers for Medicare and Medicaid Services Authorized Quality Improvement Organization's (QIO) Medical Care Review Process: Modest
- 225* Surprise Out of Network Bills: Modest
- 226* Support for Interoperability of Clinical Data: Modest
- 227* CMS Proposal to Consolidate Evaluation and Management Services (RESOLUTION WITHDRAWN): Modest
- 228# Medication Assisted Treatment: Minimal
- 229# Addressing Surgery Performed by Optometrists: Minimal
- 230# Nonprofit Hospitals and Network Health Systems: Modest
- 231# Reducing the Regulatory Burden in Health Care: Modest
- 232# Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries: Modest
- 233# Opposing Unregulated, Non-Commercial Firearm Manufacturing: Modest
- 234# Negligent Credentialing Actions Against Hospitals: Modest
- 603* Support of AAIP's Desired Qualifications for Indian Health Service Director: Minimal
- 604# Physician Health Policy Opportunity: Modest
- 801 Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle: Minimal
- 802 Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk): Est cost of \$100K includes: develop educ content within the AMA's educ platforms, requires contract w experts and vendor to produce content, and (2) a vendor to conduct background research, develop framework for resources and tools. (UPDATED FISCAL NOTE)
- 803 Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of "Dense Breasts" on Mammogram: Minimal
- 804# Arbitrary Documentation Requirements for Outpatient Services (REVISED): Modest
- 805 Prompt Pay: Minimal
- 806* Telemedicine Models and Access to Care in Post-Acute and Long-Term Care: Modest
- 807* Emergency Department Copayments for Medicaid Beneficiaries: Minimal
- 808* The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940): Modest
- 809* Medicaid Clinical Trials Coverage: Modest
- 810* Medicare Advantage Step Therapy: Modest
- 811* Infertility Benefits for Active-Duty Military Personnel (RESOLUTION WITHDRAWN): Modest
- 812* ICD Code for Patient Harm from Payer Interference: Minimal
- 813* Direct Primary Care Health Savings Account Clarification: Modest
- 814* Prior Authorization Relief in Medicare Advantage Plans: Modest
- 815* Uncompensated Physician Labor: Minimal
- 816* Medicare Advantage Plan Inadequacies: Modest
- 817* Increase Reimbursement for Psychiatric Services: Minimal
- 818* Drug Pricing Transparency: Modest
- 819* Medicare Reimbursement Formula for Oncologists Administering Drugs: Modest
- 820* Ensuring Quality Health Care for Our Veterans: Modest

SUMMARY OF FISCAL NOTES (I-18)

Resolution(s)

- 821* Direct Primary Care and Concierge Medicine Based Practices: Modest
- 822# Bone Density Reimbursement: Modest
- 823# Medicare Cuts to Radiology Imaging: Modest
- 826# Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients: Modest
- 901 Support for Preregistration in Biomedical Research: Minimal
- 902 Increasing Patient Access to Sexual Assault Nurse Examiners: Minimal
- 903 Regulating Front-of-Package Labels on Food Products: Minimal
- 904 Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service: Minimal
- 905 Support Offering HIV Post Exposure Prophylaxis to all Survivors of Sexual Assault: Minimal
- 906 Increased Access to Identification Cards for the Homeless Population: Minimal
- 908 Increasing Accessibility to Incontinence Products: Minimal
- 911 Regulating Tattoo and Permanent Makeup Inks: Modest
- 912 Comprehensive Breast Cancer Treatment: Minimal
- 913 Addressing the Public Health Implications of Pornography: Minimal
- 914 Common Sense Strategy for Tobacco Control and Harm Reduction: Modest
- 915* Mandatory Reporting: Minimal
- 916* Ban on Tobacco Flavoring Agents with Respiratory Toxicity: Minimal
- 917* Protect and Maintain the Clean Air Act: Minimal
- 918* Allergen Labeling on Food Packaging: Minimal
- 919* Opioid Mitigation: Estimated cost of \$130K to implement resolution includes evaluation, review and report development detailing programs in Huntington, WV and Clark County, IN. Estimate includes staff time, travel and professional fees.
- 920* Continued Support for Federal Vaccination Funding: Modest
- 921* Food Environments and Challenges Accessing Healthy Food: Minimal
- 922# Full Information on Generic Drugs: Minimal
- 923# Scoring of Medication Pills: Minimal
- 924# Utilizing Blood from "Therapeutic" Donations: Minimal
- 926# E-Cigarettes, Revisited: Modest
- 951 Prevention of Physician and Medical Student Suicide: Minimal
- 952 IMG Section Member Representation on Committees/Task Forces/Councils: Minimal
- 953 Support for the Income-Driven Repayment Plans: Modest
- 954 VHA GME Funding: Modest
- 955 Equality for COMLEX and USMLE: Modest
- 956 Increasing Rural Rotations During Residency: Modest
- 957 Board Certifying Bodies: Estimated cost of \$30,000 includes staff time and travel and meeting expenses
- 958* National Health Service Corps Eligibility: Modest
- 959* Physician and Medical Student Mental Health and Suicide: Estimated cost of \$588K includes creation of a Suicide Prevention Committee; policy development; widespread and repeated messaging to physicians and medical students through AMA's existing communication channels, i.e. email and social; ongoing work with state medical licensing boards and hospitals to help remove any stigma related to mental health illness; and establishment of a 24/7 mental health hotline staffed by mental health professionals.
- 960* Inadequate Residency Slots: Modest
- 961* Protect Physician-Led Medical Education: Modest
- 962* Improve Physician Health Programs (RESOLUTION WITHDRAWN): Minimal

SUMMARY OF FISCAL NOTES (I-18)

Resolutions not for consideration

- 601 Creation of an AMA Election Reform Committee: Estimated cost between 15\$ - \$25K (for 1 - 2 meetings depending on logistical arrangements includes travel and meeting costs, and staff time.
- 602* AMA Policy Statement with Editorials: The cost of implementing this resolution is varied given the large volume of content across the 13 journals in the JAMA Network, as well as the wealth of AMA policy. At a minimum, implementation would require the addition of 3 full-time staff and would result in increased operational costs associated with extra paper, printing, binding, mailing, and layout of larger print issues.
- 824# Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs: Modest
- 825# Preservation of the Patient-Physician Relationship: Modest
 - 907 Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing: Minimal
 - 909 Use of Person-Centered Language: Minimal
 - 910 Shade Structures in Public and Private Planning and Zoning Matters: Minimal
- 925# Eliminating the Death Toll from Combustible Cigarettes: Modest

*** included in the Handbook Addendum**

Minimal - less than \$1,000

Modest - between \$1,000 - \$5,000

Moderate - between \$5,000 - \$10,000

**ORDER OF BUSINESS
SECOND SESSION**

**Sunday, November 11, 2018
8:00 AM**

- 1. Report of the Committee on Rules and Credentials - David T. Walsworth, MD, Chair**
- 2. Presentation, Correction and Adoption of Minutes of 2018 Annual Meeting**
- 3. Remarks of the Speaker - Susan R. Bailey, MD**
- 4. Announcement of Changes in Reference Committees**
- 5. Report(s) of the Board of Trustees - Jack Resneck, Jr., MD, Chair**
 - 01 Data Used to Apportion Delegates (F)
 - 02 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
 - 03 2018 AMA Advocacy Efforts (Info. Report)
 - 04 Increased Use of Body-Worn Cameras by Law Enforcement Officers (B)
 - 05 Exclusive State Control of Methadone Clinics (B)
 - 06 Update on TruthinRx Grassroots Campaign (Info. Report)
 - 07 Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs (B)
 - 08 340B Drug Discount Program (B)
 - 09 Hospital Closures and Physician Credentialing (J)
 - 10 Training Physicians in the Art of Public Forum (F)
 - 11 Violence Prevention (B)
 - 12 Information Regarding Animal-Derived Medications (K)
 - 13 2019 Strategic Plan (Info. Report)
 - 14 Protection of Physician Freedom of Speech (Amendments to C&B)
 - 15# Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)
- 6. Report(s) of the Council on Ethical and Judicial Affairs - James E. Sabin, MD, Chair**
 - 01* Competence, Self-Assessment and Self-Awareness (Amendments to C&B)
 - 02* Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician-Assisted Suicide" and "Aid-in-Dying" (Amendments to C&B)
 - 03* Amendment to E-2.2.1, "Pediatric Decision Making" (Amendments to C&B)
 - 04* CEJA Role in Implementing H-140.837, "Anti-Harassment Policy" (Amendments to C&B)
 - 05* Physicians' Freedom of Speech (Amendments to C&B)
- 7. Opinion(s) of the Council on Ethical and Judicial Affairs - James E. Sabin, MD, Chair**
 - 01 Medical Tourism (Info. Report)
 - 02 Expanded Access to Investigational Therapies (Info. Report)
 - 03* Mergers of Secular and Religiously Affiliated Health Care Institutions - CORRECTED (Info. Report)
- 8. Report(s) of the Council on Long Range Planning and Development - Alfred Herzog, MD, Chair**
 - 01 Women Physicians Section Five-Year Review (F)

9. Report(s) of the Council on Medical Education - Carol D. Berkowitz, MD, Chair

- 01 Competency of Senior Physicians (C)
- 02 Review of AMA Educational Offerings (Info. Report)
- 03 Developing Physician-Led Public Health / Population Health Capacity in Rural Communities (C)
- 04 Reconciliation of AMA Policy on Primary Care Workforce (C)
- 05* Reconciliation of AMA Policy on Medical Student Debt (C)
- 06 Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours (C)
- 07 50th Anniversary of the AMA Physicians' Recognition Award and Credit System (Info. Report)
- 08 Study of Medical Student, Resident and Physician Suicide (Info. Report)

10. Report(s) of the Council on Medical Service - James G. Hinsdale, MD, Chair

- 01 Prescription Drug Importation for Personal Use (J)
- 02 Air Ambulance Regulations and Payments (J)
- 03* Sustain Patient-Centered Medical Home Practices (J)
- 04 The Site-of-Service Differential (J)

11. Report(s) of the Council on Science and Public Health - Robyn F. Chatman, MD, Chair

- 01* Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (K)
- 02* FDA Expedited Review Programs and Processes (K)

12. Report(s) of the HOD Committee on Compensation of the Officers - Marta J. Van Beek, MD, Chair

- 01# Report of the House of Delegates Committee on Compensation of the Officers (REVISED) (F)

13. Joint Report(s)

- CMS-CSAPH 01* Aligning Clinical and Financial Incentives for High-Value Care (J)

14. Report(s) of the Speakers - Susan R. Bailey, MD, Speaker; Bruce A. Scott, MD, Vice Speaker

- 01 Recommendations for Policy Reconciliation (Info. Report)

--EXTRACTION OF INFORMATIONAL REPORTS--

15. Unfinished business

16. New Business (Introduction of Resolutions)

- 001 Support of a National Registry for Advance Directives (Amendments to C&B)
- 002* Protecting the Integrity of Public Health Data Collection (Amendments to C&B)
- 003* Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children (Amendments to C&B)
- 004# Opposing the Detention of Migrant Children (Amendments to C&B)
- 201 Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application (B)
- 202# Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings - REVISED (B)
- 203 Support for the Development and Distribution of HIPAA-Compliant Communication Technologies (B)
- 204 Restriction on IMG Moonlighting (B)
- 205 Legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (B)
- 206 Repealing Potential Penalties Associated with MIPS (B)

207 Defense of Affirmative Action (B)

208 Increasing Access to Broadband Internet to Reduce Health Disparities (B)

209 Sexual Assault Education and Prevention in Public Schools (B)

210 Forced Organ Harvesting for Transplantation (B)

211 Eliminating Barriers to Automated External Defibrillator Use (B)

212 Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings (B)

213 Increasing Firearm Safety to Prevent Accidental Child Deaths (B)

214 A Public Health Case for Firearm Regulation (B)

215* Extending the Medical Home to Meet Families Wherever They Go (B)

216* Medicare Part B Competitive Acquisition Program (CAP) (B)

217* Opposition to Medicare Part B to Part D Changes (B)

218# Alternatives to Tort for Medical Liability - REVISED (B)

219* Promotion and Education of Breastfeeding (B)

220* Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement (B)

221* Regulatory Relief from Burdensome CMS "HPI" EHR Requirements (B)

222* Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS (B)

223* Permanent Reauthorization of the State Children's Health Insurance Program (B)

224* Fairness in the Centers for Medicare and Medicaid Services Authorized Quality Improvement Organization's (QIO) Medical Care Review Process (B)

225* Surprise Out of Network Bills (B)

226* Support for Interoperability of Clinical Data (B)

227* CMS Proposal to Consolidate Evaluation and Management Services (RESOLUTION WITHDRAWN) (B)

228# Medication Assisted Treatment (B)

229# Addressing Surgery Performed by Optometrists (B)

230# Nonprofit Hospitals and Network Health Systems (B)

231# Reducing the Regulatory Burden in Health Care (B)

232# Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries (B)

233# Opposing Unregulated, Non-Commercial Firearm Manufacturing (B)

234# Negligent Credentialing Actions Against Hospitals (B)

603* Support of AAIP's Desired Qualifications for Indian Health Service Director (F)

604# Physician Health Policy Opportunity (F)

801 Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle (J)

802 Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk) (J)

803 Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of "Dense Breasts" on Mammogram (J)

804# Arbitrary Documentation Requirements for Outpatient Services (REVISED) (J)

805 Prompt Pay (J)

806* Telemedicine Models and Access to Care in Post-Acute and Long-Term Care (J)

807* Emergency Department Copayments for Medicaid Beneficiaries (J)

808* The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940) (J)

809* Medicaid Clinical Trials Coverage (J)
810* Medicare Advantage Step Therapy (J)
811* Infertility Benefits for Active-Duty Military Personnel (RESOLUTION WITHDRAWN) (J)
812* ICD Code for Patient Harm from Payer Interference (J)
813* Direct Primary Care Health Savings Account Clarification (J)
814* Prior Authorization Relief in Medicare Advantage Plans (J)
815* Uncompensated Physician Labor (J)
816* Medicare Advantage Plan Inadequacies (J)
817* Increase Reimbursement for Psychiatric Services (J)
818* Drug Pricing Transparency (J)
819* Medicare Reimbursement Formula for Oncologists Administering Drugs (J)
820* Ensuring Quality Health Care for Our Veterans (J)
821* Direct Primary Care and Concierge Medicine Based Practices (J)
822# Bone Density Reimbursement (J)
823# Medicare Cuts to Radiology Imaging (J)
826# Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients (J)
901 Support for Preregistration in Biomedical Research (K)
902 Increasing Patient Access to Sexual Assault Nurse Examiners (K)
903 Regulating Front-of-Package Labels on Food Products (K)
904 Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service (K)
905 Support Offering HIV Post Exposure Prophylaxis to all Survivors of Sexual Assault (K)
906 Increased Access to Identification Cards for the Homeless Population (K)
908 Increasing Accessibility to Incontinence Products (K)
911 Regulating Tattoo and Permanent Makeup Inks (K)
912 Comprehensive Breast Cancer Treatment (K)
913 Addressing the Public Health Implications of Pornography (K)
914 Common Sense Strategy for Tobacco Control and Harm Reduction (K)
915* Mandatory Reporting (K)
916* Ban on Tobacco Flavoring Agents with Respiratory Toxicity (K)
917* Protect and Maintain the Clean Air Act (K)
918* Allergen Labeling on Food Packaging (K)
919* Opioid Mitigation (K)
920* Continued Support for Federal Vaccination Funding (K)
921* Food Environments and Challenges Accessing Healthy Food (K)
922# Full Information on Generic Drugs (K)
923# Scoring of Medication Pills (K)
924# Utilizing Blood from "Therapeutic" Donations (K)
926# E-Cigarettes, Revisited (K)
951 Prevention of Physician and Medical Student Suicide (C)
952 IMG Section Member Representation on Committees/Task Forces/Councils (C)
953 Support for the Income-Driven Repayment Plans (C)
954 VHA GME Funding (C)
955 Equality for COMLEX and USMLE (C)
956 Increasing Rural Rotations During Residency (C)

- 957 Board Certifying Bodies (C)
- 958* National Health Service Corps Eligibility (C)
- 959* Physician and Medical Student Mental Health and Suicide (C)
- 960* Inadequate Residency Slots (C)
- 961* Protect Physician-Led Medical Education (C)
- 962* Improve Physician Health Programs (RESOLUTION WITHDRAWN) (C)

17. Presentation of Recommendations for Items of Business to Not be Considered at Interim Meeting

- 601 Creation of an AMA Election Reform Committee (Not for consideration)
- 602* AMA Policy Statement with Editorials (Not for consideration)
- 824# Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs (Not for consideration)
- 825# Preservation of the Patient-Physician Relationship (Not for consideration)
- 907 Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing (Not for consideration)
- 909 Use of Person-Centered Language (Not for consideration)
- 910 Shade Structures in Public and Private Planning and Zoning Matters (Not for consideration)
- 925# Eliminating the Death Toll from Combustible Cigarettes (Not for consideration)

18. Report of the Committee on Rules and Credentials - David T. Walsworth, MD, Chair

** contained in the Handbook Addendum*

contained in the Sunday Tote

ORDER OF BUSINESS

Reference Committee on Amendments to Constitution and Bylaws (I-18)
Todd M. Hertzberg, MD, Chair

November 10, 2018
Potomac A

Gaylord Maryland Resort and Convention Center
Baltimore

1. Board of Trustees Report 14 – Protection of Physician Freedom of Speech
2. Board of Trustees Report 15 – Specialty Society Representation in the House of Delegates – Five-Year Review
3. Council on Ethical and Judicial Affairs Report 1 – Competence, Self-Assessment and Self-Awareness
4. Council on Ethical and Judicial Affairs Report 2 – Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish “Physician Assisted Suicide” and “Aid-in-Dying”
5. Council on Ethical and Judicial Affairs Report 3 – Amendment to E-2.2.1, “Pediatric Decision Making”
6. *Resolution 1001 – Affirming the Medical Spectrum of Gender*
7. Council on Ethical and Judicial Affairs Report 4 – CEJA Role in Implementing H-140.837, “Anti-Harassment Policy”
8. Council on Ethical and Judicial Affairs Report 5 – Physicians’ Freedom of Speech
9. Resolution 001 – Support of a National Registry for Advance Directives
10. Resolution 002 – Protecting the Integrity of Public Health Data Collection
11. Resolution 003 – Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children
12. Resolution 004 – Opposing the Detention of Migrant Children

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ORDER OF BUSINESS

Reference Committee B (I-18)
Francis P. MacMillan, Jr., MD, Chair

November 11, 2018
Potomac B

Gaylord National
National Harbor, MD

1. Board of Trustees Report 4 – Increased Use of Body-Worn Cameras by Law Enforcement Officers (Resolution 208-I-17)
2. Board of Trustees Report 5 – Exclusive State Control of Methadone Clinics (Resolution 211-I-17)
3. Board of Trustees Report 7 – 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)
4. Board of Trustees Report 8 – 340B Drug Discount Program (Resolution 225-A-18 Resolve 3)
5. Board of Trustees Report 11 – Violence Prevention (Resolution 419-A-18, Resolves 1 and 3)
Resolution 213 – Increasing Firearm Safety to Prevent Accidental Child Deaths
Resolution 214 – A Public Health Case for Firearm Regulation
Resolution 233 – Opposing Unregulated, Non-Commercial Firearm Manufacturing
6. Resolution 212 – Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings
7. *Resolution 201 – Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application*
8. Resolution 202 – Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
9. *Resolution 228 – Medication Assisted Treatment*
10. *Late Resolution 1002 – Inappropriate Use of CDC Guidelines for Prescribing Opioids*
11. *Resolution 203 – Support for the Development and Distribution of HIPAA-Compliant Communication Technologies*
12. Resolution 204 – Restriction on IMG Moonlighting
13. Resolution 205 – Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
14. Resolution 206 – Repealing Potential Penalties Associated with MIPS
Resolution 231 – Reducing the Regulatory Burden in Health Care
15. *Resolution 207 – Defense of Affirmative Action*
16. *Resolution 208 – Increasing Access to Broadband Internet to Reduce Health Disparities*
17. Resolution 215 – Extending the Medical Home to Meet Families Wherever They Go
18. Resolution 209 – Sexual Assault Education and Prevention in Public Schools
19. Resolution 210 – Forced Organ Harvesting for Transplantation
20. Resolution 211 – Eliminating Barriers to Automated External Defibrillator Use
21. Resolution 216 – Medicare Part B Competitive Acquisition Program (CAP)
22. Resolution 217 – Opposition to Medicare Part B to Part D Changes
23. *Resolution 218 – Alternatives to Tort for Medical Liability*

24. *Resolution 219 – Promotion and Education of Breastfeeding*
25. Resolution 220 – Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement
26. *Resolution 221 – Regulatory Relief from Burdensome CMS "HPI" EHR Requirements*
27. *Resolution 222 – Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS*
28. *Resolution 223 – Permanent Reauthorization of the State Children’s Health Insurance Program*
29. *Resolution 224 – Fairness in the Centers for Medicare & Medicaid Services Authorized Quality Improvement Organization’s (QIO) Medical Care Review Process*
30. *Resolution 225 – “Surprise” Out of Network Bills*
31. *Resolution 226 – Support for Interoperability of Clinical Data*
32. Resolution 229 – Addressing Surgery Performed by Optometrists
33. Resolution 230 – Nonprofit Hospitals and Network Health Systems
34. Resolution 232 – Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries
35. Resolution 234 – Negligent Credentialing Actions Against Hospitals

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ORDER OF BUSINESS

Reference Committee C (I-18)
Peter C. Amadio, MD, Chair

November 11, 2018
National Harbor 10-11

Gaylord National Resort & Convention Center
National Harbor, Maryland

1. Council on Medical Education Report 5, Reconciliation of AMA Policy on Medical Student Debt
2. Resolution 953, Support for the Income-Driven Repayment Plans
3. *Resolution 958, National Health Service Corps Eligibility*
4. Resolution 952, IMG Section Member Representation on Committees/Task Forces/Councils
5. Resolution 961, Protect Physician-Led Medical Education
6. Resolution 955, Equality for COMLEX & USMLE
7. Council on Medical Education Report 6, Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours
8. Council on Medical Education Report 4, Reconciliation of AMA Policy on Primary Care Workforce
9. Resolution 960, Inadequate Residency Slots
10. Council on Medical Education Report 3, Developing Physician-Led Public Health/Population Health Capacity in Rural Communities
11. *Resolution 956, Increasing Rural Rotations During Residency*
12. Resolution 954, VHA GME Funding
13. Resolution 951, Prevention of Physician and Medical Student Suicide
14. Resolution 959, Physician and Medical Student Mental Health and Suicide
15. Council on Medical Education Report 1, Competency of Senior Physicians
16. Resolution 957, Board Certifying Bodies

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

ORDER OF BUSINESS

Reference Committee F (I-18)
Greg Tarasidis, MD, Chair

November 11, 2018
Maryland Ballroom

Gaylord Maryland Resort and Convention Center
Baltimore

1. Report of the House of Delegates Committee on Compensation of the Officers
2. Board of Trustees Report 1 – Data Used to Apportion Delegates
3. Board of Trustees Report 10 – Training Physicians in the Art of Public Forum
4. Council on Long Range Planning and Development Report 1 – Women Physicians Section Five-Year Review
5. Resolution 603 – Support of AAIP’s “Desired Qualifications for Indian Health Service Director”
6. Resolution 604 – Physician Health Policy Opportunity
7. *Resolution 601 – Creation of an AMA Election Reform Committee*
8. *Resolution 602 – AMA Policy Statement with Editorials*

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

ORDER OF BUSINESS

Reference Committee J (I-18)
Steven Chen, MD, Chair

November 11, 2018
Potomac Ballroom C

Gaylord Maryland Resort and Convention Center
National Harbor

1. Board of Trustees Report 9 - Hospital Closures and Physician Credentialing
2. Council on Medical Service Report 1 - Prescription Drug Importation for Personal Use
3. Council on Medical Service Report 2 - Air Ambulance Regulations and Payments
4. Council on Medical Service Report 3 - Sustain Patient-Centered Medical Home Practices
5. Council on Medical Service Report 4 - The Site-of-Service Differential
6. Resolution 823 - Medicare Cuts to Radiology Imaging
7. Joint Report of the Council on Medical Service and the Council on Science and Public Health - Aligning Clinical and Financial Incentives for High-Value Care
8. Resolution 803 - Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of "Dense Breasts" on Mammogram
9. Resolution 804 - Arbitrary Documentation Requirements for Outpatient Services
10. Resolution 805 - Prompt Pay
11. Resolution 801 - Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle
12. Resolution 807 - Emergency Department Copayments for Medicaid Beneficiaries
13. *Resolution 809 - Medicaid Clinical Trials Coverage*
14. Resolution 802 - Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk)
15. *Resolution 806 - Telemedicine Models and Access to Care in Post-Acute and Long-Term Care*

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16. *Resolution 808 - The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940)*
17. Resolution 812 - ICD Code for Patients Harm From Payer Interference
18. *Resolution 814 - Prior Authorization Relief in Medicare Advantage Plans*
19. *Resolution 816 - Medicare Advantage Plan Inadequacies*
20. *Resolution 810 - Medicare Advantage Step Therapy*
21. *Resolution 819 - Medicare Reimbursement Formula for Oncologists Administering Drugs*
22. *Resolution 813 - Direct Primary Care Health Savings Account Clarification*
Resolution 821 - Direct Primary Care and Concierge Medicine Based Practices
23. Resolution 820 - Ensuring Quality Health Care for Our Veterans
24. *Resolution 815 - Uncompensated Physician Labor*
25. *Resolution 817 - Increase Reimbursement for Psychiatric Services*
26. Resolution 822 - Bone Density Reimbursement
27. *Resolution 818 - Drug Pricing Transparency*
28. *Resolution 824 - Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs*
29. *Resolution 825 - Preservation of the Patient-Physician Relationship*
30. Resolution 826 - Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients

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ORDER OF BUSINESS

Reference Committee K (I-18)
Darlyne Menscer, MD, Chair

November 11, 2018
Potomac D

Gaylord Maryland Resort and Convention Center
National Harbor

1. Board of Trustees Report 12 – Information Regarding Animal-Derived Medications (Resolution 515-A-18)
2. Council on Science and Public Health Report 1 – Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals
3. Council on Science and Public Health Report 2 – Improving FDA Expedited Approval Pathways
4. Resolution 911 – Regulating Tattoo and Permanent Makeup Inks
5. *Resolution 922 – Full Information on Generic Drugs*
6. *Resolution 923 – Scoring of Medication Pills*
7. *Resolution 924 – Utilizing Blood from “Therapeutic” Donations*
8. Resolution 918 – Allergen Labeling on Food Packaging
9. Resolution 903 – Regulating Front-of-Package Labels on Food Products
10. Resolution 921 – Food Environments and Challenges Accessing Healthy Food
11. *Resolution Late 1003 – Oppose FDA’s Decision to Approve Primatene Mist HFA for Over the Counter Use*
12. Resolution 901 – Support for Preregistration in Biomedical Research
13. Resolution 902 – Increasing Patient Access to Sexual Assault Nurse Examiners
14. Resolution 905 – Support Offering HIV Post Exposure Prophylaxis to all Survivors of Sexual Assault
15. Resolution 904 – Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service
16. Resolution 906 – Increased Access to Identification Cards for the Homeless Population
17. *Resolution 907 – Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing*
18. Resolution 913 – Addressing the Public Health Implications of Pornography
19. Resolution 908 – Increasing Accessibility Incontinence Products
20. *Resolution 909 – Use of Person-Centered Language*
21. *Resolution 910 – Shade Structures in Public and Private Planning and Zoning Matters*
22. Resolution 912 – Comprehensive Breast Cancer Treatment
23. Resolution 915 – Mandatory Reporting
24. Resolution 917 – Protect and Maintain the Clean Air Act
25. Resolution 919 – Opioid Mitigation
26. *Resolution 920 – Continued Support for Federal Vaccination Funding*
27. Resolution 916 – Ban on Tobacco Flavoring Agents with Respiratory Toxicity
28. *Resolution 925 – Eliminating the Death Toll from Combustible Cigarettes*
29. Resolution 914 – Common Sense Strategy for Tobacco Control and Harm Reduction
Resolution 926 – E-Cigarettes, Revisited

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Report of the AMPAC Board of Directors

Presented by: Vidya S. Kora, MD
Chair

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

AMPAC Membership Fundraising

AMPAC raised a combined total \$2,132,989 in hard and corporate fund for the 2018 election cycle. As in previous election years, AMPAC's Capitol Club participation played a key role in bolstering AMPAC receipts and thank you to those who stepped up with your generous support. Through November, Capitol Club has 905 members which surpasses last year's year-end total of 896 members. AMPAC's Capitol Club Platinum currently has 86 members, Capitol Club Gold has 249 members and Capitol Club Silver has 570 members, a 7 percent increase over last year. Capitol Club continues to be an important part of AMPAC's fundraising efforts and improves every year.

The AMA's House of Delegate overall participation in AMPAC is currently 80 percent, with 68 percent of these members participating at the Capitol Club level. Your support at the Capitol Club level is critically important as it provides an opportunity to help advance the AMA's advocacy mission in Washington, DC which is required for success in today's political environment.

AMPAC is hosting its annual Capitol Club luncheon on Monday, November 12 and all current Capitol Club Platinum, Gold and Silver contributors are invited to attend this ticketed event. Charlie Cook, a well-respected bi-partisan political handicapper and analyst will recap the 2018 election and provide insight on what lies ahead for both parties. Also, during this event the winner of AMPAC's annual sweepstakes will be announced with the prizewinner enjoying a beautiful getaway to LTM Auberge de Sedona in Sedona's famed red rock region in September 2019. All 2018 Platinum, Gold and Silver contributors are automatically entered in the sweepstakes drawing.

As one election cycle ends, the next one begins. We can only be as effective as we are united in our efforts to support our own advocacy efforts and we need your continued support as leaders of the AMA House of Delegates. If you have haven't contributed to AMPAC for 2018 or would like to join or renew your AMPAC membership for 2019, please stop by AMPAC's booth which is in the AMA's exhibit area.

Political Action

The 2018 elections presented AMPAC with a difficult political landscape to navigate. Health care was at the forefront of the national political debate and fierce battle lines were drawn between many Republicans advocating repeal of the Affordable Care Act which would reduce insurance coverage, versus Democrats proposing single payer or “Medicare for All” plans that would stifle delivery reform, reduce patient choice and threaten physician practice sustainability.

Because AMPAC remains bipartisan and is not a single-issue group, the challenge was working to find candidates who were not on the extreme end of their respective party’s spectrum. Solutions-oriented politicians who can compromise to make progress on complicated health care issues include more moderate Republicans who have moved on from the repeal ACA rhetoric and centrist Democrats who are not solely focused on enacting single-payer. Those lawmakers on both sides of the aisle who value the AMA’s guidance on issues impacting patient care have helped move the needle on timely issues including increased funding for NIH research, easing physicians’ administrative burdens and defending against threats of federal encroachment to the way states regulate the practice of medicine.

AMPAC incorporated valuable feedback from state medical society PACs and local physicians from around the country as it worked to identify candidates that would fit this mold and make for sound investments on behalf of organized medicine. In all, AMPAC contributed \$1.4 million in the 2018 cycle that included direct contributions to 291 physician-friendly candidates for the U.S. House and Senate from both political parties (51% to Republicans and 49% to Democrats). These contributions provided more than 600 strategic opportunities for AMA lobbyists, physician leaders and local doctors to attend events and have important one-to-one interactions discussing issues critical to medicine. As the cost of elections continues to spiral ever higher, AMPAC is finding its value-add is our ability to create these opportunities.

Big-spending outside groups and dark money operations must remain independent and cannot have communications or interactions with candidates. Their heavy-hitting negative messaging is solely focused on affecting the outcome of elections in the current cycle and stands in stark contrast to AMPAC’s strategy of long-term relationship building with leaders in Congress, members of key committees and those lawmakers considered to be true champions of medicine.

From a broader perspective, a total of 250 AMPAC supported candidates won election/reelection. This included medicine’s top allies currently in Congress as well as a number of incoming freshmen that the AMA is eager to begin building relationships with and educating them on the issues that matter most to physicians. The total number of physicians in Congress also has increased, up from 13 to now 16. New physician members include AMPAC-supported John Joyce, MD (R, PA-13), Mark Green, MD (R, TN-7), and Kim Shrier, MD (D, WA-8).

Political Education Programs

On December 6-9, 24 physicians, medical students, physician spouses and state medical society staff will take part in the 2018 Campaign School at the AMA offices in Washington, DC. These participants are already preparing by taking part in online “pre-school” work that will allow them to hit the ground running in December. As the recent midterm elections confirmed, running an effective campaign can be the difference between winning and losing a race. The AMPAC Campaign School will give participants the skills and strategic approach they will need out on the campaign trail. Participants will be placed into campaign teams and by using a hands-on approach our team of

political experts will run them through a simulated campaign, teaching them everything they need to know to run a successful race.

AMPAC is also close to finalizing the dates for the 2019 Candidate Workshop so be on the lookout for more information on how to register soon.

I am also proud to announce that nominations are now open for the AMPAC Award for Political Participation. Formerly the Belle Chenault Award for Political Participation, the award recognizes an AMA or AMA Alliance member for outstanding accomplishment through volunteer activities in a political campaign or a significant health care related election issue such as a ballot initiative or referendum in the 2018 elections. Deadline to submit a nomination is January 31, 2019.

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

Conclusion

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

Informational Reports

BOT Report(s)

- 02 Redefining AMA's Position on ACA and Healthcare Reform
- 03 2018 AMA Advocacy Efforts
- 06 Update on TruthinRx Grassroots Campaign
- 13 2019 Strategic Plan

CEJA Opinion(s)

- 01 Medical Tourism
- 02 Expanded Access to Investigational Therapies
- 03* Mergers of Secular and Religiously Affiliated Health Care Institutions - CORRECTED

CME Report(s)

- 02 Review of AMA Educational Offerings
- 07 50th Anniversary of the AMA Physicians' Recognition Award and Credit System
- 08 Study of Medical Student, Resident and Physician Suicide

Report of the Speakers

- 01 Recommendations for Policy Reconciliation

* contained in the Handbook Addendum

contained in the Sunday Tote

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 14 Protection of Physician Freedom of Speech
- 15# Specialty Society Representation in the House of Delegates - Five-Year Review

CEJA Report(s)

- 01* Competence, Self-Assessment and Self-Awareness
- 02* Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish "Physician-Assisted Suicide" and "Aid-in-Dying"
- 03* Amendment to E-2.2.1, "Pediatric Decision Making"
- 04* CEJA Role in Implementing H-140.837, "Anti-Harassment Policy"
- 05* Physicians' Freedom of Speech

Resolution(s)

- 001 Support of a National Registry for Advance Directives
- 002* Protecting the Integrity of Public Health Data Collection
- 003* Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children
- 004# Opposing the Detention of Migrant Children

* contained in the Handbook Addendum

contained in the Sunday Tote

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-I-18

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

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

1 The Board of Trustees (BOT) has completed its review of the specialty organizations seated in
2 the House of Delegates (HOD) scheduled to submit information and materials for the 2018
3 American Medical Association (AMA) Interim Meeting in compliance with the five-year
4 review process established by the House of Delegates in Policy G-600.020, "Summary of
5 Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw
6 8.5, "Periodic Review Process."

7
8 Organizations are required to demonstrate continuing compliance with the guidelines
9 established for representation in the HOD. Compliance with the five responsibilities of
10 professional interest medical associations and national medical specialty organizations is also
11 required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty
12 Societies and Professional Interest Medical Associations."

13
14 The following organizations were reviewed for the 2018 Interim Meeting:

15
16 American Academy of Allergy, Asthma & Immunology
17 American Academy of Ophthalmology, Inc.
18 American Academy of Orthopaedic Surgeons
19 American Academy of Otolaryngology-Head and Neck Surgery
20 American Academy of Pain Medicine
21 American Academy of Pediatrics
22 American Academy of Physical Medicine & Rehabilitation
23 American Association of Neurological Surgeons
24 Society of Nuclear Medicine and Molecular Imaging

25
26 The Society of Nuclear Medicine and Molecular Imaging was reviewed at this time because
27 they failed to meet the requirements of the review in 2017.

28
29 Each organization was required to submit materials demonstrating compliance with the
30 guidelines and requirements along with appropriate membership information. A summary of
31 each group's membership data is attached to this report (Exhibit A). A summary of the
32 guidelines for specialty society representation in the AMA HOD (Exhibit B), the five
33 responsibilities of national medical specialty organizations and professional medical interest
34 associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-
35 year review process (Exhibit D) are also attached.

1 The materials submitted indicate that: American Academy of Allergy, Asthma & Immunology,
2 American Academy of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons,
3 American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Pain
4 Medicine, American Academy of Pediatrics, American Academy of Physical Medicine &
5 Rehabilitation, American Association of Neurological Surgeons and the Society of Nuclear
6 Medicine and Molecular Imaging are in compliance with all requirements for representation in
7 the HOD.

8
9 **RECOMMENDATIONS**

10
11 The Board of Trustees recommends that the following be adopted and the remainder of this
12 report be filed:

13
14 That the American Academy of Allergy, Asthma & Immunology, American Academy
15 of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons, American
16 Academy of Otolaryngology-Head and Neck Surgery, American Academy of Pain
17 Medicine, American Academy of Pediatrics, American Academy of Physical Medicine
18 & Rehabilitation, American Association of Neurological Surgeons, and the Society of
19 Nuclear Medicine and Molecular Imaging retain representation in the American
20 Medical Association House of Delegates. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Allergy, Asthma & Immunology	324 of 1,600 (20%)
American Academy of Ophthalmology, Inc.	3,021 of 17,125 (18%)
American Academy of Orthopaedic Surgeons	3,897 of 23,682 (16%)
American Academy of Otolaryngology-Head and Neck Surgery	2,081 of 8,436 (25%)
American Academy of Pain Medicine	371 of 1,208 (31%)
American Academy of Pediatrics	3,827 of 42,035 (9%)
American Academy of Physical Medicine & Rehabilitation	1,146 of 6510 (18%)
American Association of Neurological Surgeons	787 of 3,639 (22%)
Society of Nuclear Medicine and Molecular Imaging	293 of 1,361 (22%)

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

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

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

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

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

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

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-18)

Introduced by: California

Subject: Opposing the Detention of Migrant Children

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Todd M. Hertzberg, MD, Chair)

1 Whereas, The United States government has detained undocumented migrant children in
2 detention centers and the number of migrant children is now greater than 12,000 - more than
3 ever before and a fivefold increase since last year; and
4

5 Whereas, The Flores Settlement of 1997 requires the United States Government to release
6 undocumented children “without unnecessary delay” when detention is not required for the
7 protection or safety of that child; and those children that remain in custody must be placed in the
8 “least restrictive setting” possible; and
9

10 Whereas, It has been established that these detention centers can be detrimental to the health
11 of children and their subsequent development; and
12

13 Whereas, These detention centers have a documented record of medical, psychological and
14 sexual abuse of some of these children; and
15

16 Whereas, Physician whistleblowers have reported their “horror” at the conditions and treatment
17 of these children; and
18

19 Whereas, The Trump administration has already missed deadlines for the release of many
20 children and has now proposed overturning the Flores Agreement to allow the indefinite
21 detention of children with their families, and most recently, has moved many children during the
22 night out of detention centers to a tent city in Texas, with even less support and more concerns
23 regarding their welfare and prospects; therefore be it
24

25 RESOLVED, That our American Medical Association oppose the separation of migrant children
26 from their families and any effort to end or weaken the Flores Settlement that requires the
27 United States Government to release undocumented children “without unnecessary delay” when
28 detention is not required for the protection or safety of that child and that those children that
29 remain in custody must be placed in the “least restrictive setting” possible, such as emergency
30 foster care (New HOD Policy); and be it further
31

32 RESOLVED, That our AMA support the humane treatment of all undocumented children,
33 whether with families or not, by advocating for regular, unannounced, auditing of the medical
34 conditions and services provided at all detention facilities by a non-governmental, third party
35 with medical expertise in the care of vulnerable children (New HOD Policy); and be it further
36

37 RESOLVED, That our AMA urge that all children released from such detention be provided with
38 indicated follow-up health care to ensure their welfare following these experiences. (New HOD
39 Policy)

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

Received: 10/17/18

RELEVANT AMA POLICY

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992

1. Our AMA will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.
2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.
3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.
4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.
Citation: (Res. 5, I-15)

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968

Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services.
Citation: (Res. 8, I-14)

Reference Committee B

BOT Report(s)

- 04 Increased Use of Body-Worn Cameras by Law Enforcement Officers
- 05 Exclusive State Control of Methadone Clinics
- 07 Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs
- 08 340B Drug Discount Program
- 11 Violence Prevention

Resolution(s)

- 201 Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application
- 202# Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings - REVISED
- 203 Support for the Development and Distribution of HIPAA-Compliant Communication Technologies
- 204 Restriction on IMG Moonlighting
- 205 Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
- 206 Repealing Potential Penalties Associated with MIPS
- 207 Defense of Affirmative Action
- 208 Increasing Access to Broadband Internet to Reduce Health Disparities
- 209 Sexual Assault Education and Prevention in Public Schools
- 210 Forced Organ Harvesting for Transplantation
- 211 Eliminating Barriers to Automated External Defibrillator Use
- 212 Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings
- 213 Increasing Firearm Safety to Prevent Accidental Child Deaths
- 214 A Public Health Case for Firearm Regulation
- 215* Extending the Medical Home to Meet Families Wherever They Go
- 216* Medicare Part B Competitive Acquisition Program (CAP)
- 217* Opposition to Medicare Part B to Part D Changes
- 218# Alternatives to Tort for Medical Liability - REVISED
- 219* Promotion and Education of Breastfeeding
- 220* Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement
- 221* Regulatory Relief from Burdensome CMS "HPI" EHR Requirements
- 222* Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS
- 223* Permanent Reauthorization of the State Children's Health Insurance Program
- 224* Fairness in the Centers for Medicare and Medicaid Services Authorized Quality Improvement Organization's (QIO) Medical Care Review Process
- 225* Surprise Out of Network Bills
- 226* Support for Interoperability of Clinical Data
- 227* CMS Proposal to Consolidate Evaluation and Management Services (RESOLUTION WITHDRAWN)
- 228# Medication Assisted Treatment
- 229# Addressing Surgery Performed by Optometrists
- 230# Nonprofit Hospitals and Network Health Systems
- 231# Reducing the Regulatory Burden in Health Care
- 232# Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries
- 233# Opposing Unregulated, Non-Commercial Firearm Manufacturing

* contained in the Handbook Addendum

contained in the Sunday Tote

Reference Committee B

Resolution(s)

234# Negligent Credentialing Actions Against Hospitals

* contained in the Handbook Addendum
contained in the Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-18)

Introduced by: Pennsylvania

Subject: Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings

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

- 1 Whereas, The opioid-overdose epidemic has had a devastating impact throughout the United
2 States and currently claims about 115 lives per day (1); and
3
4 Whereas, The Centers for Disease Control and Prevention in August 2018 reported a record
5 72,000 overdose deaths in 2017 (2); and
6
7 Whereas, Medications for opioid use disorder can facilitate recovery and prevent deaths (3);
8 and
9
10 Whereas, Great Britain, Canada and Australia have successfully made methadone available by
11 prescription, enhancing access to this valuable therapy (1); and
12
13 Whereas, Limited experience in the United States over a 10-year period has demonstrated the
14 success of such a primary care approach for treatment of opioid use disorder (1); and
15
16 Whereas, In 2001, there was a six-month randomized controlled trial that supported the success
17 of such a primary care based approach (4, 5); and
18
19 Whereas, Enhancing the opportunity for primary care practices to prescribe methadone might
20 increase the availability of such treatment in non-urban populations who lack access to
21 methadone clinics; and
22
23 Whereas, AMA Policy H-95.957 supports further evaluation of "...properly trained practicing
24 physicians as an extension of organized methadone maintenance programs in the management
25 of those patients whose needs for allied services are minimal..."; therefore be it
26
27 RESOLVED, That our American Medical Association study the implications of removing those
28 administrative and/or legal barriers that hamper the ability of primary care physician practices to
29 dispense methadone, as part of medication assisted treatment (Directive to Take Action); and
30 be it further
31
32 RESOLVED, That our AMA study the implications of working with other Federation stakeholders
33 to identify the appropriate educational tools that would support primary care practices in
34 dispensing ongoing methadone for appropriate patients as part of medication-assisted
35 treatment. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.
Received: 10/31/18

References:

- (1) Samet JH, Botticelli MB, and Bharel M. "Perspective. Methadone in Primary Care – One Small Step for Congress, One Giant Leap for Addiction Treatment. N Eng J Med 379:7-8, 5 July 2018.
- (2) <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.
- (3) Sordo L et al. "Mortality Risk during and after opioid substitution treatment; systemic review and meta-analysis of cohort studies." BMJ 357:j1550, 2017.
- (4) Fiellin DA et al. "Methadone Maintenance in Primary Care. A Randomized Controlled Trial. JAMA 286:1724-1731, 10 Oct 2001.
- (5) Stein MD and Friedmann PD. "Editorial: Generalist Physicians and Addiction Care. From Turfing to Sharing the Turf." JAMA 286: 1764-1765, 10 Oct 2001.

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.

CSA Rep. 2 - I-94 Reaffirmed: CSA Rep. 12 and Append Res. 412, A-99 Reaffirmation I-00

Modified: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-18)

Introduced by: Colorado
 Subject: Alternatives to Tort for Medical Liability
 Referred to: Reference Committee B
 (Francis P. MacMillan, Jr., MD, Chair)

Tort Reform Proposal

Whereas, The stated purpose of mediated tort liability 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

Whereas, Patients generally have no recourse other than medical tort actions to be made whole after medical injury; and

Whereas, Linking compensation for harm to liability encourages lawsuits when there is no causal linkage between care and outcome (e.g. most cases of cerebral palsy¹); and

Whereas, The tort system typically takes 3 years to resolve cases, if they go to court, and usually in favor of defendants leaving most harmed patients uncompensated at the end of a long, inefficient and expensive process; and

Whereas, Only a small number of medical errors trigger a tort action leaving most cases of medical harm unaddressed; and

Whereas, Most medical injuries are not the result of negligence²; and

Whereas, 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

Whereas, 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.⁶² ... 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.^{64, 65} ... clinicians and others must know that safety can be improved by non-punitive reporting of error and that organizational flaws cause errors.¹;" and

¹ <https://www.cdc.gov/ncbddd/cp/causes.html>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3576054/>

1 Whereas, Research has shown a 5% cost reduction in hospital costs when the threat of tort
2 litigation is removed³; and

3
4 Whereas, Our AMA does have considerable policy on medical liability reform (H-435.973,
5 H-435.969, D 435.992), but none of these address the type of reform that is suggested below
6 for further study; and

7
8 Whereas, Candor, developed jointly by the Iowa Medical Society and the Iowa Association for
9 Justice⁴ is one example among others such as the longstanding system in New Zealand⁵;
10 therefore be it

11
12 RESOLVED, That our American Medical Association study and/or develop options for
13 alternatives to the tort system that will:

- 14 • Assure fair compensation to individuals harmed as a result of systems or clinician
15 error in the process of receiving medical care and separately
- 16 • Identify and hold accountable physicians, other practitioners and health care
17 delivery systems for questionable practice through professional review and
18 quality management as well as
- 19 • Identify opportunities for improving systems to maximize the safety of medical
20 care (as in New Zealand and other countries or the Candor strategy). (Directive
21 to Take Action)

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

Received: 10/05/18

³ <http://www.nber.org/papers/w24846>

⁴ https://www.iowamedical.org/IOWA/Iowa_Public/Resources/Center_for_Physician_Advocacy/Candor/Iowa_Public/Issues/Candor/Candor.aspx

⁵ <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2013/vol-126-no-1371/article-wallis>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(I-18)

Introduced by: Georgia
Subject: Medication Assisted Treatment
Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Despite education efforts that have led to a reduction in rates of opioid prescribing
2 since 2011, the number of opioid overdose deaths continues to rise; and
3
4 Whereas, In 2017 there were over 72,000 opioid overdose deaths in the United States, and four
5 Georgians die every day from opioid overdose; and
6
7 Whereas, Only 10% of people with addiction are getting treatment; and
8
9 Whereas, Medication assisted therapy with medications such as methadone and buprenorphine
10 has been shown to reduce medical complications, reduce the likelihood of overdose, and
11 improve remission rates; and
12
13 Whereas, Buprenorphine is safer than methadone; and
14
15 Whereas, Access to medication assisted treatment is very limited due to inadequate education
16 of providers in medication assisted therapy, and an insufficient number of providers who meet
17 current legislative requirements to prescribe buprenorphine; and
18
19 Whereas, Ability to prescribe buprenorphine requires completion of eight hours of training as
20 well as application for a DEA waiver, and assignment of a special DEAx number; and
21
22 Whereas, Even with a DEA waiver, physicians are authorized to treat limited numbers of
23 patients; and
24
25 Whereas, Primary care physicians and emergency rooms are a potential point of entry for
26 patients to receive medication assisted therapy; therefore be it
27
28 RESOLVED, That our American Medical Association advocate for all insurance plans (public
29 and private payers) to provide coverage for medication assisted treatment of opioid use disorder
30 by all qualified physicians. (New HOD Policy)

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

Received: 10/23/18

RELEVANT AMA POLICY

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968

Our AMA will: (1) 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; and (2) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.

Citation: Res. 222, A-18

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972

1. Our AMAs Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.

2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

Citation: Res. 506, A-17; Appended: BOT Action in response to referred for decision: Res. 506, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(I-18)

Introduced by: American Academy of Ophthalmology

Subject: Addressing Surgery Performed by Optometrists

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

- 1 Whereas, Our AMA defines surgery as “the diagnostic or therapeutic treatment of conditions or
2 disease processes by any instruments causing localized alteration or transposition of live
3 human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and
4 needles”;¹⁻² and
5
6 Whereas, Current AMA policy is unclear on who should perform surgery as defined in the
7 previous clause, stating in one policy that surgery should be performed only by “licensed
8 physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional
9 standards”¹ and in another policy that laser surgery as defined above may be performed by any
10 of “those categories of practitioners currently licensed by the state to perform surgical
11 services”;³ and
12
13 Whereas, In the states of Oklahoma (OK),⁴ Louisiana (LA),⁵ and Kentucky (KY),⁶ surgeries such
14 as ophthalmic anterior chamber laser surgeries and several scalpel surgeries are legally
15 permitted to be performed by licensed doctors of optometry (hereafter, “optometrists” or “ODs”),
16 and several states allow their state Boards of Optometry the ability to define the scope of
17 optometric practice in their states, often explicitly including ophthalmic surgeries;⁵⁻⁷ and
18
19 Whereas, A major rationale in favor of optometrists performing ophthalmic surgeries is that
20 geographic access to ophthalmologists is poor in rural areas; yet research suggests that there is
21 no significant difference in geographic access to procedures performed by optometrists
22 compared to ophthalmologists in the states in which optometrists are legally allowed to perform
23 surgical procedures;⁹ and
24
25 Whereas, Schools of optometry outside OK, LA, and KY cannot legally provide optometry
26 students clinical experience with these procedures on patients, yet OD degrees from many
27 schools of optometry outside these states are considered sufficient for licensure and the legal
28 performance of ophthalmic surgeries in LA¹⁰ and KY¹¹⁻¹⁵; and
29
30 Whereas, Graduated ODs whose degrees do not fulfill licensure requirements in OK, LA, and
31 KY may take one or both of two 16 hour courses, which contain no procedural experience on
32 patients,¹⁶⁻¹⁹ to sufficiently fulfill the licensure requirements of OK,¹⁹ LA,¹⁰ and KY¹¹⁻¹⁵ and
33 thereafter legally perform laser and scalpel procedures, respectively, in those states; and
34
35 Whereas, The AMA has noted all surgical procedures as defined in the first clause to be
36 invasive and carry inherent risk to patient safety;¹ and

1 Whereas, Surgery performed by those without sufficient background in systemic
2 pathophysiology and the practice of medicine, and supervised clinical experience performing on
3 patients the procedures for which they are to be licensed, such as is acquired in allopathic or
4 osteopathic medical school and subsequent appropriate surgical residencies and fellowships,
5 represents unnecessary risk to patients;¹ and
6

7 Whereas, This risk has been quantified by outcomes data suggesting higher likelihood of repeat
8 surgeries when performed by optometrists as compared to ophthalmologists;²¹ and
9

10 Whereas, This complete absence of physician supervision in performing surgeries or in surgical
11 training, and lack of any training performing such surgeries on patients prior to licensure to
12 perform them independently, is a problem unique to the field of optometry and separate from
13 current concerns about the scope of practice of other mid-level providers; therefore be it
14

15 RESOLVED, That our American Medical Association support legislation prohibiting optometrists
16 from performing surgical procedures as defined by AMA policies H-475.983, "Definition of
17 Surgery," and H-475.988, "Laser Surgery" (New HOD Policy); and be it further
18

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

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

Received: 10/31/18

1. American Medical Association. *Definition of Surgery*. BOT Rep. 16, A-13. H-475.983. 2013.
2. American Medical Association. *Laser Surgery*. BOT Rep. 16, A-13. H-475.988. 2013.
3. American Medical Association. *Laser Surgery*. BOT Rep. 16, A-13. H-475.989. 2013.
4. Oklahoma Senate. *Regarding the Oklahoma Pharmacy Act*. 49th Oklahoma Legislature. H.B. 2321. 2004.
5. Louisiana State Legislature. *Provides relative to the practice of optometry and the regulation of such profession*. 2014 Regular Session. Enrolled Act No. 398, H.B. 1065. 2014.
6. Kentucky Legislature. *Declaration of legislative policy concerning practice of optometry*. KRS 320. 2018.
7. Alaska State Legislature. *Relating to the practice of optometry; and providing for an effective date*. 30th Legislature (2017-2018). Enrolled H.B. 103. 2017.
8. Mahr, Michael A, and Erie, Jay C. "Comparing Access to Laser Capsulotomy Performed by Optometrists and Ophthalmologists in Oklahoma by Calculated Driving Distance and Time." *Ophthalmology*, vol. 124, no. 9, 2017, pp. 1290–1295.
9. Mahr, Michael A, and Erie, Jay C. "Comparing Access to Laser Capsulotomy Performed by Optometrists and Ophthalmologists in Oklahoma by Calculated Driving Distance and Time." *Ophthalmology*, vol. 124, no. 9, 2017, pp. 1290–1295.
10. "Colleges of Optometry Teaching Advanced Procedures." *Optometry Association of Louisiana*, Aug. 2017, https://www.optla.org/colleges_of_optometry_teaching.php. Accessed 17 Aug. 2018.
11. Kentucky Legislature. *Expanded Therapeutic Procedures*. 201 KAR 5:110. 2018.
12. *Application for New Applicants to Utilize Expanded Therapeutic Procedures*. Kentucky Board of Optometric Examiners, Aug. 2011.
13. *Application for Kentucky Licensed Optometrist to be Credentialed to Utilize Expanded Therapeutic Procedures*. Kentucky Board of Optometric Examiners, Aug. 2011.
14. *Application to Utilize Expanded Therapeutic Laser Procedure(s)*. Kentucky Board of Optometric Examiners, Aug. 2011.
15. *Application for Endorsement to be Credentialed to Utilize Expanded Therapeutic Procedures*. Kentucky Board of Optometric Examiners, Aug. 2011.
16. Northeastern State University Oklahoma College of Optometry. *NSUOCO Advanced Procedures Schedule*. 2018. optometry.nsuok.edu/Portals/5/PDF%20Files/CE/20180712-AP-Schedule.pdf. Accessed 13 Aug. 2018.
17. "Ophthalmic Laser Course Prepares Optometrists for Wider Scope of Practice." *Salus University*, 6 June 2017, <http://www.salus.edu/News/News-Stories/Ophthalmic-Laser-Course-Prepares-Optometrists-for.aspx>. Accessed 17 Aug. 2018.
18. "Optometric surgical procedures courses now available at Optometry's Meeting®." *American Optometric Association*, 1 March 2018, www.aoa.org/news/clinical-eye-care/optometric-surgical-procedures-courses. Accessed 9 Aug. 2018.
19. "2018 KOA & NSUOCO Expanded Therapeutic Course." *Kentucky Optometric Association*, <https://kyeyes.org/koa-events/etp-course/>. Accessed 17 Aug. 2018.
20. "Licensing." *Oklahoma Board Of Examiners In Optometry*, <https://optometry.ok.gov/licensing.htm>. Accessed 17 Aug. 2018.
21. Stein, Joshua D, et al. "Comparison of Outcomes of Laser Trabeculoplasty Performed by Optometrists vs Ophthalmologists in Oklahoma." *JAMA Ophthalmology*, vol. 134, no. 10, 2016, pp. 1095-1101.

RELEVANT AMA POLICY

Definition of Surgery H-475.983

Our AMA adopts the following definition of 'surgery' from American College of Surgeons Statement ST-11:

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel. Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.

Citation: Res. 212; A-07; Reaffirmed: BOT Rep. 16, A-13

Laser Surgery H-475.988

The AMA supports the position that revision, destruction, incision or other structural alteration of human tissue using laser is surgery.

Citation: (Res. 316, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: BOT Rep. 16, A-13)

Laser Surgery H-475.989

Our AMA (1) adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services; and (2) encourages state medical associations to support state legislation and rulemaking in support of this policy.

Citation: (Sub. Res. 39, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(I-18)

Introduced by: Pennsylvania
Subject: Nonprofit Hospitals and Network Health Systems
Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, The current healthcare marketplace has empowered hospital consolidation; and
2
3 Whereas, Hospitals that dominate the marketplace have excluded private practice physicians
4 being granted staff hospital privileges and practicing in “Not for Profit” institutions; and
5
6 Whereas, This is a violation of the IRS “Community Benefit Standard” - Rev. Rul. 56-185, 1956-
7 1 C.B. 202, modified Rev. Rul. 69-545, 1969-2 C.B.117; and
8
9 Whereas, The ruling states: In order for a hospital to establish that it is exempt as a public
10 charitable organization within the contemplation of section 501(c)(3), it must, among other
11 things, show that it meets the following general requirements: #3: It must not restrict the use of
12 its facilities to a particular group of physicians and surgeons, such as a medical partnership or
13 association, to the exclusion of all other qualified doctors; and
14
15 Whereas, Consolidation of Network Healthcare systems has impacted small groups and solo
16 private practices; and
17
18 Whereas, Insurance carriers collaborate with hospitals and network systems to narrow
19 healthcare networks and select products that exclude private practice participation and hospital
20 physician domination of the marketplace; and
21
22 Whereas, Healthcare facility monopolies have driven up the cost of healthcare; and
23
24 Whereas, Consolidation of healthcare facilities raises costs, decreases and limits patient access
25 to healthcare; and
26
27 Whereas, Patients of private practice physicians who request their current physicians in hospital
28 settings are redirected to employed healthcare system physicians. Private practice physicians
29 are not contacted even when a patient requests “their own” doctor; and
30
31 Whereas, The above factors limit a physician’s ability to care for their patients and sever the
32 patient/physician relationship; therefore be it

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

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

Received: 10/31/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(I-18)

Introduced by: Pennsylvania
Subject: Reducing the Regulatory Burden in Health Care
Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, At its January 11, 2018 meeting, the Medicare Payment Advisory Commission
2 (MedPAC), an independent legislative branch agency established by the Balanced Budget Act
3 of 1997 to advise Congress on the Medicare program, voted 14 to 2 to repeal the Merit-Based
4 Incentive Payment System (MIPS); and
5
6 Whereas, MedPAC, in its “Assessing Payment Adequacy and Updating Payments: Physician
7 and Other Health Professional Services; and Moving Beyond the Merit-Based Incentive
8 Payment System (MIPS)” (January 11, 2018), concluded that “MIPS cannot succeed” as it
9 “replicates flaws of prior value-based purchasing programs,” is “burdensome and complex,” and
10 “much of the reported information is not meaningful”; and
11
12 Whereas, MedPAC additionally noted in its January 11, 2018 report that MIPS scores are “not
13 comparable across clinicians,” “MIPS payment adjustments will be minimal in [the] first two
14 years, large and arbitrary in later years,” and “MIPS will not succeed in helping beneficiaries
15 choose clinicians, helping clinicians change practice patterns to improve value, or helping the
16 Medicare program to reward clinicians based on value”; and
17
18 Whereas, Eric T. Roberts, et al, in their article, “The Value-Based Payment Modifier: Program
19 Outcomes and Implications for Disparities,” (*Annals of Internal Medicine*, February 20, 2018)
20 found that the Value-Based Payment Modifier, in the context of pay-for-performance programs,
21 was “not associated with differences in performance on program measures” and furthermore,
22 Medicare’s pay-for-performance programs could potentially “exacerbate health care disparities”;
23 therefore be it
24
25 RESOLVED, That our American Medical Association work to support the repeal of the Merit-
26 Based Incentive Payment System (MIPS) (Directive to Take Action); and be it further
27
28 RESOLVED, That upon repeal of MIPS, our AMA oppose any federal efforts to implement any
29 pay-for-performance programs unless such programs add no significant regulatory or paperwork
30 burdens to the practice of medicine and have been shown, by evidence-based research, to
31 improve the quality of care for those served. (Directive to Take Action)

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

Received: 10/31/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(I-18)

Introduced by: American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, American Academy of Neurology, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Ophthalmology, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, American College of Cardiology, American College of Emergency Physicians, American College of Mohs Surgery, American College of Radiology, American College of Rheumatology, American Society for Clinical Oncology, American Society for Clinical Pathology, American Society for Radiation Oncology, American Society of Dermatopathology, American Society of Plastic Surgeons, American Urological Association, College of American Pathologists, Congress of Neurological Surgeons, Renal Physicians Association, Society for Investigative Dermatology

Subject: Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries

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

1 Whereas, Congress and the Centers for Medicare & Medicaid Services (CMS) have indicated
2 that physician-led quality measure development is a priority and many specialty societies have
3 developed both meaningful quality measures and qualified clinical data registries (QCDRs) for
4 physicians to demonstrate quality and report for federal Medicare payment incentives in Merit-
5 based Incentive Payment System (MIPS); and
6
7 Whereas, Medical specialty societies devote extensive resources to measure development,
8 data collection, data validation and ongoing measure stewardship. The data collected through
9 QCDRs are used not only for MIPS reporting, but also for research and analysis used to support
10 guideline development and quality initiatives; and
11
12 Whereas, CMS proposes that, as a condition of a QCDR measure's approval for purposes of
13 MIPS, QCDR measure owners be required to enter into a license agreement with CMS such
14 that once a QCDR measure is approved for reporting in MIPS, it would be generally available
15 for other QCDRs to report on for purposes of MIPS without a fee for use and without a direct
16 license with the measure owner; and
17
18 Whereas, The CMS proposal undermines QCDR measure ownership and development and
19 violates the intellectual property rights of QCDR measure owners, as QCDR measures are
20 subject to copyright protection; and
21
22 Whereas, This proposal is a sudden and unwarranted reversal of the current policy that CMS
23 adopted just last year to protect the intellectual property rights of QCDR measure owners; and

1 Whereas, Without the ability to license measures and collect fees to offset the cost of
2 developing and stewarding measures, QCDR measure owners have no way to control the
3 appropriate use of their measures and cannot responsibly invest in measure development; and
4

5 Whereas, QCDRs should be able to enforce their ownership rights in the QCDR measures they
6 develop, and to require third parties to enter into licensing agreements with measure owners
7 that before they can properly use QCDR measures, and these licensing agreements could
8 include appropriate financial remuneration and responsibility for data integrity; therefore be it
9

10 RESOLVED, That our American Medical Association actively oppose any Centers for Medicare
11 & Medicaid Services (CMS) proposal that would require qualified clinical data registry (QCDR)
12 measure owners, as a condition of measure approval for reporting in the Merit-based Incentive
13 Payment System and other Medicare quality payment programs, to enter into a license
14 agreement with CMS that would allow other QCDRs to use the owner's measures without a fee
15 or without a direct license with the measure owner. (Directive to Take Action)

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

Received: 10/31/18

RELEVANT AMA POLICY

Clinical Data Registries H-450.933

1. Our AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs.
 2. Our AMA encourages national medical specialty societies, state medical associations, and other physician groups to join the National Quality Registry Network and to participate in efforts to advance the development and use of clinical data registries.
 3. Our AMA supports flexibility in the development and implementation of clinical data registries. The following guidelines can help maximize opportunities for clinical data registries to enhance the quality of care provided to patients:
 - a. Practicing physicians must be actively involved in decisions related to the development, maintenance and use of clinical data registries and registry data.
 - b. Data elements, risk-adjustment models and measures used in the registry should be fully transparent.
 - c. Registries should provide timely, actionable feedback reports to individual physicians or entities reporting at the organizational level.
 - d. Registries and electronic health records should be interoperable, and should be capable of sharing and integrating information across registries and with other data sources in a HIPAA-compliant and confidential manner.
 - e. Registry stewards should establish a formal process to facilitate the modification, expansion, or dissolution of the registry in order to accommodate advances in technology and changing clinical data needs to ensure continued utility of their registry.
 4. Our AMA encourages physicians to participate in clinical data registries, and will encourage efforts that help physicians identify existing registries suitable for and of benefit to their patient populations and their practices.
 5. Our AMA will continue to advocate for and support initiatives that minimize the costs and maximize the benefits of physician practice participation in clinical data registries.
 6. Our AMA supports that, with the consent of the participating physician, physician-specific clinical registry data may be used to meet third-party quality reporting requirements, in accordance with the following principles:
 - a. Data should be used to improve the quality of patient care and the efficient use of resources in the delivery of health care services.
 - b. Data related to resource use and cost of care must be evaluated and reported in conjunction with quality of care information.
 - c. Effective safeguards must be established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
 - d. Case-matched, risk-adjusted quality measure and resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients.
 - e. When data are collected and analyzed for the purpose of meeting quality reporting requirements, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians, and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure.
- Citation: CMS Rep. 8, A-14; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(I-18)

Introduced by: Medical Student Section
Subject: Opposing Unregulated, Non-Commercial Firearm Manufacturing
Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, The United States has the highest rate of gun ownership in the world with 120.5 guns
2 per 100 residents, indicating that the U.S. has more guns than residents;¹ and
3
4 Whereas, Evidence across ecological, cross-sectional, and case-control studies suggests that
5 gun availability is a significant risk factor for homicide and suicide;^{2,3} and
6
7 Whereas, A 2015 study found that a 1% increase in firearm ownership rates is associated with
8 an average increase of 0.16 deaths by suicide per 100,000 individuals;³ and
9
10 Whereas, The case fatality rate of firearm suicide is 85%, making firearms the most lethal
11 means of suicide attempt;⁴ and
12
13 Whereas, In 2015, 73% of homicide victims were murdered with a firearm (12,979 deaths) and
14 50% of suicides were completed with a firearm (22,018 deaths);⁵ and
15
16 Whereas, 3-D printers cost less than \$1,000, thus, there is a concern that the accessibility of
17 this technology could lead to the proliferation of amateur gun making in homes across the U.S.;⁶
18 and
19
20 Whereas, 3-D printed guns pose a threat because they are easy to fabricate, may not look like
21 real guns, and may be especially appealing to children and adolescents;^{6,7} and
22
23 Whereas, On August 1, 2018, the U.S. State Department prepared to allow the “Defense
24 Distributed” firm to publish gun blueprints for 3-D printers, although this was overturned by a
25 federal judge;^{8,9} and
26
27 Whereas, Hundreds of blueprint designs were reportedly downloaded prior to this court
28 decision;⁸ and
29
30 Whereas, With access to a 3-D printer, downloading a firearm blueprint enables the
31 manufacturing of a plastic, untraceable firearm without a criminal background check or a serial
32 number requirement, such as an AR-15 semi-automatic assault weapon;^{8,9} and
33
34 Whereas, Metal parts may be added to make 3-D printed firearms legal under the Undetectable
35 Firearms Act of 1988, although these firearms are still manufactured without a criminal
36 background check or a serial number;⁹ and

1 Whereas, There is precedent for municipality law, such as that of New South Wales in Australia,
2 to regulate blueprints that may be used to 3-D print firearms;¹⁰ and
3

4 Whereas, The U.S. has taken previous action prohibiting the demonstration of manufacturing or
5 usage of explosives, destructive devices, or weapons of mass destruction as well as any means
6 of distribution of information pertaining to the manufacturing or use of the aforementioned
7 devices;¹¹ and
8

9 Whereas, Using blueprints to 3-D print firearms will increase access to guns in an unregulated
10 manner, and the literature suggests that increased access results in an increase in the number
11 of homicides and suicides;^{2,3,4} therefore be it
12

13 RESOLVED, That our American Medical Association support legislation that opposes: a)
14 unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the
15 material composition or detectability of such weapons; b) production and distribution of 3-D
16 firearm blueprints (New HOD Policy); and be it further
17

18 RESOLVED, That our AMA issue a statement of concern to Congress and the Bureau of
19 Alcohol, Tobacco, Firearms and Explosives regarding the manufacturing of firearms using 3-D
20 printers and the online dissemination of 3-D firearm blueprints as a public health issue.
21 (Directive to Take Action)

Fiscal note: Modest: Between \$1,000 - \$5,000.

Date received: 09/23/2018

References:

1. Small Arms Survey. Global Firearms Holdings. <http://www.smallarmssurvey.org/weapons-and-markets/tools/global-firearms-holdings.html>. Accessed September 1, 2018.
2. Anglemeyer A, Horvath T, Rutherford G. The accessibility of firearms and risk for suicide and homicide victimization among household members: a systematic review and meta-analysis. *Ann Int Med*. 2014; 160(2):101-110.
3. Miller M, Warren M, Hemenway D, et al. Firearms and suicide in US cities. *Injury Prev*. 2015; 21:e116-e119.
4. Fowler KA, Dahlberg LL, Haileyesus T, Annest JL. Firearm injuries in the United States. *Prev Med*. 2015; 79:5–14.
5. Murphy SL, Xu JQ, Kochanek KD, Curtin SC, Arias E. Deaths: Final data for 2015. *National Vital Statistics Reports*; vol 66 no 6. Hyattsville, MD: National Center for Health Statistics. 2017. Accessed September 20, 2018.
6. Johnson J. Print, Lock, and Load: 3-D Printers, Creation of Guns, and the Potential Threat to Fourth Amendment Rights. *Journal of Law, Technology, and Policy*. 2013. (2):337-361.
7. Bilton, Nick. The Rise of 3-D Printed Guns. *The New York Times*. August 13, 2014. <https://www.nytimes.com/2014/08/14/fashion/the-rise-of-3-d-printed-guns.html>. Accessed September 1, 2018.
8. Almsy, S. A judge ruled that a website has to suspend downloads for 3D gun plans. But they're already out there. *CNN*. August 1, 2018. <https://www.cnn.com/2018/07/31/us/3d-guns-downloaded-plans-states/index.html> Accessed September 1, 2018.
9. Williams, D. Americans can legally download 3-D printed guns starting next month. *CNN*. July 20, 2018. <https://www.cnn.com/2018/07/19/us/3d-printed-gun-settlement-trnd/index.html>. Accessed September 1, 2018.
10. New South Wales Government (2015). *Firearms and Weapons Prohibition Legislation Amendment Bill 2015*. New South Wales.
11. 18 U.S.C. § 842; 2011.

RELEVANT AMA POLICY:

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.

Firearm Availability H-145.996

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

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.

Control of Non-Detectable Firearms H-145.994

The AMA supports a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(I-18)

Introduced by: Organized Medical Staff Section
Subject: Negligent Credentialing Actions Against Hospitals
Referred to: Reference Committee B
(Francis P. MacMillan, Jr., MD, Chair)

1 Whereas, Patients' rights are already protected under various medical liability or medical
2 malpractice laws that provide them with the right to sue for any injuries resulting from
3 professional negligence by their physicians, as well as hospital liability under a wide range of
4 events (e.g., slip and falls, hospital-borne infections, faulty equipment, etc.); and
5
6 Whereas, Nevertheless, many courts in the United States recognize another cause of action—
7 negligent credentialing, a tort action allowing patients to sue a hospital for any injuries caused
8 by a physician based on the theory that the hospital granted privileges to that physician when it
9 should not have; and
10
11 Whereas, Recently, the Kentucky Supreme Court refused to recognize negligent credentialing
12 as a cause of action because its far-reaching implications are largely unknown; and
13
14 Whereas, The threat of liability for negligent credentialing may result in hospitals and health
15 plans adopting much more stringent criteria to credential licensed physicians, making the
16 credentialing process another significant barrier for physicians, and in effect, could give rise to
17 patient access and quality of care issues; therefore be it
18
19 RESOLVED, That our American Medical Association recognize that “negligent credentialing”
20 lawsuits undermine the overall integrity of the credentialing process, potentially resulting in
21 adverse impacts to patient access and quality of care (New HOD Policy); and be it further
22
23 RESOLVED, That our AMA actively oppose state legislation and court action recognizing
24 “negligent credentialing” as a cause of action that would allow for patients to sue a hospital
25 and/or medical staff (Directive to Take Action); and be it further
26
27 RESOLVED, That our AMA work with state medical societies and medical specialty
28 associations in those states that recognize the tort of negligent credentialing to advocate that
29 such claims should place the highest standard of proof on the plaintiff. (Direct to Take Action)

Fiscal note: Modest: Between \$1,000 - \$5,000.

Received: 11/10/2018

Reference Committee C

CME Report(s)

- 01 Competency of Senior Physicians
- 03 Developing Physician-Led Public Health / Population Health Capacity in Rural Communities
- 04 Reconciliation of AMA Policy on Primary Care Workforce
- 05* Reconciliation of AMA Policy on Medical Student Debt
- 06 Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours

Resolution(s)

- 951 Prevention of Physician and Medical Student Suicide
- 952 IMG Section Member Representation on Committees/Task Forces/Councils
- 953 Support for the Income-Driven Repayment Plans
- 954 VHA GME Funding
- 955 Equality for COMLEX and USMLE
- 956 Increasing Rural Rotations During Residency
- 957 Board Certifying Bodies
- 958* National Health Service Corps Eligibility
- 959* Physician and Medical Student Mental Health and Suicide
- 960* Inadequate Residency Slots
- 961* Protect Physician-Led Medical Education
- 962* Improve Physician Health Programs (RESOLUTION WITHDRAWN)

* contained in the Handbook Addendum

contained in the Sunday Tote

Reference Committee F

BOT Report(s)

- 01 Data Used to Apportion Delegates
- 10 Training Physicians in the Art of Public Forum

CLRPD Report(s)

- 01 Women Physicians Section Five-Year Review

HOD Comm on Compensation of the Officers

- 01# Report of the House of Delegates Committee on Compensation of the Officers (REVISED)

Resolution(s)

- 603* Support of AAIP's Desired Qualifications for Indian Health Service Director
- 604# Physician Health Policy Opportunity

* contained in the Handbook Addendum

contained in the Sunday Tote

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

REVISED REPORT

Comp. Comte. Report I-18

Subject: Report of the House of Delegates Committee on Compensation of the Officers

Presented by: Marta J. Van Beek, MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

1 This report by the Committee at the 2018 Interim Meeting presents one recommendation. It also
2 documents the compensation paid to Officers for the period July 1, 2017 thru June 30, 2018 and
3 includes the 2017 calendar year IRS reported taxable value of benefits, perquisites, services, and
4 in-kind payments for all Officers.

5
6 BACKGROUND

7
8 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
9 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the
10 “Committee”). The Officers are defined in the American Medical Association’s (AMA)
11 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the
12 HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among
13 whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and
14 Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition,
15 appointment, tenure, vacancy process and reporting requirements for the Committee are covered
16 under the AMA Bylaws. Bylaws 2.13.4.5 provides:

17
18 The Committee shall present an annual report to the House of Delegates recommending the
19 level of total compensation for the Officers for the following year. The recommendations of
20 the report may be adopted, not adopted or referred back to the Committee, and may be
21 amended for clarification only with the concurrence of the Committee.

22
23 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s
24 definition of total compensation which was added to the Glossary of the AMA Constitution and
25 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an
26 individual for work performance including: (a) all forms of money or cash compensation; (b)
27 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

28
29 Since the inception of this Committee, its reports document the process the Committee follows to
30 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective
31 compensation practices as derived from research and use of independent external consultants,
32 expert in Board compensation. Reports beginning in December 2002 documented the principles
33 the Committee followed in creating its recommendations for Officer compensation.

34
35 At A-08, the HOD approved changes that simplified compensation practices with increased
36 transparency and consistency. At A-10, Reference Committee F requested that this Committee

1 recommend that the HOD affirm a codification of the current compensation principle, which
2 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
3 its recommendations for Officer compensation on the principle of the value of the work performed,
4 consistent with IRS guidance and best practices as recommended by the Committee's external
5 independent consultant, who is expert in Board compensation.
6

7 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
8 with that of all other Officers (excluding Presidents and Chair) because these positions perform
9 comparable work.
10

11 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
12 Group, to update his 2007 research by providing the Committee with comprehensive advice and
13 counsel on Officer compensation. The updated compensation structure was presented and
14 approved by the HOD at I-11 with an effective date of July 1, 2012.
15

16 The Committee's I-13 report recommended and the HOD approved the Committee's
17 recommendation to provide a travel allowance for each President to be used for upgrades because
18 of the significant volume of travel in representing our AMA.
19

20 At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
21 Huddleston, an expert in Board Compensation with Willis Towers Watson, the Committee
22 recommended and the HOD approved modest increases to the Governance Honorarium and Per
23 Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. A-
24 17's report, approved by the HOD, modified the Governance Honorarium and Per Diem definition
25 so that Internal Representation, in excess of eleven days, receives a per diem.
26

27 At A-18, based on a compensation review focused on the Presidents' and Chairs' compensation,
28 the Committee recommended and the House approved a modest increase to their Honoraria, the
29 first increase in ten years.
30

31 CASH COMPENSATION SUMMARY

32

33 The cash compensation of the Officers shown in the following table will not be the same as
34 compensation reported annually on the AMA's IRS Form 990 because Form 990s are based on a
35 calendar year. The total cash compensation in the summary is compensation for the days these
36 Officers spent away from home on AMA business approved by the Board Chair. The total cash
37 compensation in the summary includes work as defined by the Governance Honorarium and Per
38 Diem for Representation including conference calls with groups outside of the AMA, totaling 2
39 hours or more per calendar day as approved by the Board Chair. Detailed definitions are in the
40 Appendix.

1 The summary covers July 1, 2017 to June 30, 2018

AMA Officers	Position	Total Compensation	Total Days
Maya A Babu, MD, MBA	Resident Officer	\$ 5,400	0
Susan R Bailey, MD	Speaker, House of Delegates	\$ 96,850	50.5
David O Barbe, MD, MHA	President	\$ 279,000	161
Willarda V Edwards, MD, MBA	Officer	\$ 67,600	48
Jesse M Ehrenfeld, MD, MPH	Secretary & Young Physician Officer	\$ 131,650	90
E Scott Ferguson, MD	Officer	\$ -	2.5
Sandra A Fryhofer, MD	Officer	\$ -	4
Andrew W Gurman, MD	Immediate Past President	\$ 274,000	98
Gerald E Harmon, MD	Chair	\$ 269,500	91.5
Patrice A Harris, MD, MA	Immediate Past Chair	\$ 150,600	120.5
William E Kobler, MD	Officer	\$ 92,950	63
Russell WH Kridel, MD	Officer	\$ 70,200	47
Barbara L McAneny, MD	President-Elect	\$ 274,000	135
William A McDade, MD, PhD	Officer	\$ 74,100	60
Mario E Motta, MD	Officer	\$ -	2
S Bobby Mukkamala, MD	Officer	\$ 65,000	43.5
Albert J Osbahr, III, MD	Officer	\$ 78,000	54.5
Stephen R Permut, MD, JD	Officer	\$ 89,050	68
Jack Resneck, Jr, MD	Chair-Elect	\$ 199,500	94.5
Ryan J Ribeira, MD, MPH	Resident Officer	\$ 66,300	39
Karthik V Sarma, MS	Medical Student Officer	\$ 102,050	85.5
Bruce A Scott, MD	Vice Speaker, House of Delegates	\$ 78,650	55.5
Carl A Sirio, MD	Officer	\$ 106,600	78.5
Georgia A Tuttle, MD	Officer	\$ 85,800	60.5
Kevin W Williams, MSA	Public Board Member Officer	\$ 65,000	43.5

2 President, President-Elect, Immediate Past President and Chair

3 In 2017-2018, each of these positions received an annual Governance Honorarium which was paid
 4 in monthly increments. These four positions spent a total of 485.5 days on approved Assignment
 5 and Travel, or 121.4 days each on average.

6

7 Chair-Elect

8 This position received a Governance Honorarium of approximately 75% of the Governance
 9 Honorarium provided to the Chair.

10

11 All other Officers

12 All other Officers received cash compensation, which included a Governance Honorarium of
 13 \$65,000 paid in monthly installments. The remaining cash compensation is for Assignment and
 14 Travel Days that are approved by the Board Chair to externally represent the AMA. These days
 15 were compensated at a per diem rate of \$1,300.

16

17 Assignment and Travel Days

18 The total Assignment and Travel Days for all Officers (excluding the President, President-Elect,
 19 Immediate Past President and Chair) were 1110.5; this includes reimbursement for telephonic
 20 representation meetings for external organizations that are 30 minutes or longer during a calendar
 21 day and total 2 or more hours. These are reimbursed at ½ of the current per diem rate. During this
 22 reporting period, there were 18 reimbursed calls, representing 9 per diem days.

1 EXPENSES

2
3 Total expenses paid for the period, July 1, 2017 – June 30, 2018, \$798,212 compared to \$844,506
4 for the previous period, representing a 5.5% decrease. This includes \$1,907 in upgrades for
5 Presidents’ travel per the approved Presidential Upgrade Allowance of \$2,500 per position per
6 term.

7
8 BENEFITS, PERQUISITES, SERVICES AND IN-KIND PAYMENTS

9
10 Officers are able to request benefits, perquisites, services and in-kind payments, as defined in the
11 “AMA Board of Trustees Standing Rules on Travel and Expenses.” These non-taxable business
12 expense items are provided to assist the Officers in performing their duties:

- 13
14
- 15 • AMA Standard laptop computer or iPad
 - 16 • iPhone
 - 17 • American Express card (for AMA business use)
 - 18 • Combination fax/printer/scanner
 - 19 • An annual membership to the airline club of choice offered each year during the Board member’s tenure
 - 20 • Personalized AMA stationery, business cards and biographical data for official use.
- 21

22 Additionally, all Officers are eligible for \$305,000 term life insurance and are covered under the
23 AMA’s \$500,000 travel accident policy and \$10,000 individual policy for medical costs arising out
24 of any accident while traveling on official business for the AMA. Life insurance premiums paid by
25 the AMA are reported as taxable income. Also, travel assistance is available to all Officers when
26 traveling more than 100 miles from home or internationally.

27
28 Secretarial support, other than that provided by AMA’s Board office, is available up to defined
29 annual limits as follows: President, during the Presidential year, \$15,000; \$5,000 each for the
30 President-Elect, Chair, Chair-Elect and Immediate Past president per year. Secretarial expenses
31 incurred by other Officers in connection with their official duties are paid up to \$750 per year per
32 Officer. This is reported as taxable income.

33
34 Travel expenses incurred by family members are not reimbursable, except for the family of the
35 incoming President at the Annual Meeting of the HOD.

36
37 Calendar year taxable life insurance and taxable secretarial fees reported to the IRS totaled \$28,791
38 and \$28,750 respectively for 2017. An additional \$5,750 was paid to third parties for secretarial
39 services during 2017.

40
41 METHODOLOGY

42
43 Periodically, the issue of health insurance for the Presidents has been brought to this Committee’s
44 attention. Specifically, what our AMA can do to assist our President(s) when replacement health
45 insurance is needed because he/she loses health insurance coverage at his/her practice, university or
46 hospital (collectively referred to as “Employer”) when they reduce their work schedule to fulfill
47 their responsibilities as President, President-Elect or Immediate Past President. While this has
48 occurred infrequently, the Committee wanted our AMA to be prepared going forward. In
49 researching possible solutions, the Committee’s objective was to arrive at a solution that was
50 fiscally responsible to the AMA, require the President to have some responsibility for the premium

1 cost and provide flexibility to address each President's health insurance needs based on his/her
2 family demographics. An annual stipend to assist the President(s) seemed to meet this goal.

3
4 To determine the amount of the stipend, premiums were obtained from the Health Insurance
5 Marketplace ("Exchange") established under the Patient Protection and Affordable Care Act of
6 2010 to obtain the specific amounts of 2018 premiums. The Committee reviewed the Plan designs
7 offered on the Exchange and determined that the Gold Plan would be the basis for the stipend. The
8 Gold Plan's actuarial value is that the plan covers 80% of expenses. Gold Plan design can vary by
9 state but the actuarial equivalent of the design must be to cover 80% of expenses. In addition,
10 insurance carriers, plan availability, premium amounts and the scope of the network varies state to
11 state down to county level within a state. Premiums are individually determined based on the home
12 zip code of the family and the demographics of each covered family member.

13
14 Demographics of the full Board were used to obtain a broader cross-section of Gold Plan premiums
15 across the country. Board members who qualify for Medicare were excluded from the analysis and
16 would not be eligible for a stipend. With the assistance of AMA's external employee benefits
17 broker, premiums were anonymously obtained based on each Board member's state of residence,
18 and demographics.

19
20 The range of the premiums was significant which demonstrated the need for a "customized"
21 stipend. The Committee determined that the stipend would reflect a "cost-sharing" of the premium
22 for the President and covered family members. Premiums would also change annually. Medicare-
23 eligible President(s) would not be eligible to receive a stipend.

24
25 President(s) who lose his/her employer insurance would substantiate his/her eligibility for an
26 annual stipend by written notice to the Board Chair detailing the effective date of the loss and
27 listing covered family members. The amount of the stipend will be reported as taxable income for
28 the President each calendar year and will be included in this Committee's annual report to the
29 House, which documents compensation paid to Officers and the IRS reported taxable value of
30 benefits, perquisites, services and in-kind payments.

31 32 FINDINGS

33
34 The Committee notes that the President-Elect, President and Immediate Past President
35 responsibilities require a significant time commitment in supporting our AMA in governance and
36 representation functions. Our A-18 report noted that this level of responsibility results in a time
37 commitment well above that required by other not-for-profit boards. The level of commitment
38 needed in supporting our AMA may necessitate a President reduce his/her work schedule with
39 his/her employer to a part-time status which may result in a President losing his/her eligibility for
40 employer's health insurance coverage.

41
42 This Committee considers health insurance a necessity. As such, this Committee recommends that
43 Presidents who are not Medicare-eligible receive a stipend based on 70% of the then current Gold
44 Plan premium for the President and his/her covered family members once the President provides
45 written notice to the Board Chair about the loss of coverage. The stipend would be reported as
46 taxable income to the President(s).

1 RECOMMENDATIONS

2

3 The Committee on Compensation of the Officers recommends the following recommendations be
4 adopted and the remainder of this report be filed:

5

6 1. That there be no change to the current Definitions effective July 1, 2018 as they appear in the
7 Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per
8 Diem for External Representation and Telephonic Per Diem for External Representation.

9

10 2. Annual Health Insurance Stipend (Stipend)

11 The purpose of this payment is to provide a Health Insurance Stipend (Stipend) to compensate
12 the President, President-Elect and Immediate Past President under age 65, when the
13 President(s) loses his/her employer-provided ~~medical~~ health insurance coverage during his/her
14 term. President(s) who lose his/her employer insurance will substantiate his/her eligibility for
15 the Stipend by written notice to the Board Chair detailing the effective date of the loss of
16 coverage and listing covered family members. The President receiving the Stipend will have
17 the sole discretion to determine the appropriate health insurance coverage for the
18 himself/herself and the family, and provide proof of purchasing such coverage to the Board
19 Chair.

20

21 The amount of the Stipend will be 70% of the then current Gold Plan premium in the
22 President(s) state/county of residence for each covered family member. If there are multiple
23 Gold Plans in the state/county, the Stipend will be based on the average of the then current
24 Gold Plan premiums. The amount of the Stipend will be updated January 1 of each Plan year
25 based on then Gold Plan premiums and covered family members. Should a President reach age
26 65 during his/her term(s), the Stipend will end the month Medicare coverage begins. In all
27 cases the Stipend will end the sooner the President(s) obtains other health insurance coverage,
28 reaches age 65 or the month following the end of his/her term as Immediate Past President.
29 The Stipend will be paid monthly. The amount of the Stipend will be reported as taxable
30 income for the President each calendar year and will be included in this Committee's annual
31 report to the House which documents compensation paid to Officers and the IRS reported
32 taxable value of benefits, perquisites, services and in-kind payments.

33

34 3. Except as noted above, there will be no other changes to the Officers' compensation for the
35 period beginning January 1, 2019. (Directive to Take Action)

Fiscal Note: The maximum annual stipend is estimated at \$87,000. This is based on 70% of the
highest 2018 Gold Plan Premium based on current Board demographics and assumes all three
Presidents and spouses/partners would receive the stipend in the same year.

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	\$290,160
Immediate Past President & President-Elect	\$284,960
Chair	\$284,960 \$280,280
Chair-Elect	\$280,280 \$207,480
Other Officers	\$207,480 \$65,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation day.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is \$1,300 per day.

Definition of Telephonic Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or \$650.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-18)

Introduced by: Washington
Subject: Physician Health Policy Opportunity
Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

1 Whereas, Many practicing physicians are experiencing a significant amount of frustration in the
2 current practice of medicine; and
3
4 Whereas, Part of this frustration stems from the lack of understanding by federal and state
5 governments, and other regulatory agency personnel about the clinical practice of medicine and
6 the impact of over burdensome regulations; and
7
8 Whereas, It is helpful to have experienced physicians with clinical experience serving in
9 government regulatory agencies to help those agencies understand how clinical medicine
10 works; and
11
12 Whereas, Practicing physicians who are interested in gaining expertise in health policy have
13 limited options to be placed in federal government or other regulatory agency positions if they
14 choose to transition out of the clinical practice of medicine mid-career; and
15
16 Whereas, In the prior decade, the majority of Robert Wood Johnson Foundation Fellows have
17 been physicians (MD or DO); and
18
19 Whereas, Only two of the current eight Robert Wood Johnson Foundation Fellows are
20 physicians (MD or DO); therefore be it
21
22 RESOLVED, That our American Medical Association, working with the state and specialty
23 societies, make it a priority to give physicians the opportunity to serve in federal and state health
24 care agency positions by providing the training and transitional opportunities to move from
25 clinical practice to health policy (Directive to Take Action); and be it further
26
27 RESOLVED, That our AMA study and report back to the House of Delegates at the 2019 Interim
28 Meeting with findings and recommendations for action on how best to increase opportunities to
29 train physicians in transitioning from clinical practice to health policy (Directive to Take Action);
30 and be it further
31
32 RESOLVED, That our AMA explore the creation of an AMA health policy fellowship, or work
33 with the Robert Wood Johnson Foundation to ensure that there are designated physician
34 fellowship positions within their Health Policy Fellowship program to train physicians in
35 transitioning from clinical practice to health policy. (Directive to Take Action)

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

Received: 10/19/18

Reference Committee J

BOT Report(s)

09 Hospital Closures and Physician Credentialing

CMS Report(s)

01 Prescription Drug Importation for Personal Use

02 Air Ambulance Regulations and Payments

03* Sustain Patient-Centered Medical Home Practices

04 The Site-of-Service Differential

Joint Report(s)

CMS-CSAPH 01* Aligning Clinical and Financial Incentives for High-Value Care

Resolution(s)

801 Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle

802 Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk)

803 Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of "Dense Breasts" on Mammogram

804# Arbitrary Documentation Requirements for Outpatient Services (REVISED)

805 Prompt Pay

806* Telemedicine Models and Access to Care in Post-Acute and Long-Term Care

807* Emergency Department Copayments for Medicaid Beneficiaries

808* The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940)

809* Medicaid Clinical Trials Coverage

810* Medicare Advantage Step Therapy

811* Infertility Benefits for Active-Duty Military Personnel (RESOLUTION WITHDRAWN)

812* ICD Code for Patient Harm from Payer Interference

813* Direct Primary Care Health Savings Account Clarification

814* Prior Authorization Relief in Medicare Advantage Plans

815* Uncompensated Physician Labor

816* Medicare Advantage Plan Inadequacies

817* Increase Reimbursement for Psychiatric Services

818* Drug Pricing Transparency

819* Medicare Reimbursement Formula for Oncologists Administering Drugs

820* Ensuring Quality Health Care for Our Veterans

821* Direct Primary Care and Concierge Medicine Based Practices

822# Bone Density Reimbursement

823# Medicare Cuts to Radiology Imaging

826# Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients

* contained in the Handbook Addendum

contained in the Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-18)

Introduced by: Alaska

Subject: Arbitrary Documentation Requirements for Outpatient Services

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

- 1 Whereas, Onerous administrative requirements can reduce practice efficiency and contribute to
2 physician burnout, without improving patient care; and
3
4 Whereas, Fee for service payers including Medicare and Medicaid have historically advised that
5 clinical documentation for outpatient services should be completed in a “timely manner” (or
6 within some other non-specific timeframe); and
7
8 Whereas, A new Alaska Medicaid regulation arbitrarily imposes a “72 hour” rule, prohibiting
9 payment for any outpatient claim unless documentation for the provided service had been
10 substantively completed within three days of the visit (including weekends/holidays); and
11
12 Whereas, Neither government nor private health insurers should unilaterally impose
13 burdensome documentation requirements without at least some evidence that the new rules will
14 improve patient outcomes; and
15
16 Whereas, Alaska’s new regulation also includes a provision that the three day requirement shall
17 be waived if a provider’s professional body has adopted policy specifying that a longer time
18 period for documentation is appropriate; therefore be it
19
20 RESOLVED, That our American Medical Association agree that documentation for outpatient
21 physician services should be completed in a timely manner (New HOD Policy); and be it further
22
23 RESOLVED, That our AMA work with government health plans and private insurers to help
24 them better understand the unintended consequences of imposing documentation rules with
25 unrealistically short timeframes, and that our AMA oppose the use of such rules or regulations in
26 determining whether submitted claims are valid and payable. (Directive to Take Action)

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

Received: 09/28/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 822
(I-18)

Introduced by: Georgia
Subject: Bone Density Reimbursement
Referred to: Reference Committee J
(Steven Chen, MD, Chair)

1 Whereas, Bone health is a serious medical problem leading to 1,500,000 fractures a year; and

2
3 Whereas, Unfortunately, as noted on the National Osteoporosis Foundation website: “since
4 2007, Medicare has been significantly cutting the funding for DXA testing in physician’s offices
5 leading to a sharp decline in the number of people tested, diagnosed and treated. As a result,
6 new research indicates the incidence of hip fractures which had been declining, is now once
7 again on the rise;” and

8
9 Whereas, The ISCD website notes the following payments as of 2015 for DXA and VFA in the
10 Office Setting:

- 11 • CPT 77080: DXA performed alone– \$40.46 (\$30.07 technical component and \$10.38
12 professional component)
- 13 • CPT 77085: DXA and VFA performed together– \$56.57 (\$41.17 technical component
14 and \$15.39 professional component)
- 15 • CPT 77086: VFA performed alone–\$35.80 (\$26.85 technical component and \$8.95
16 professional component).
- 17 • DXA and VFA reimbursement in the Facility Outpatient setting:
- 18 • CMS has “packaged” services that are integral, ancillary, supportive, dependent or
19 adjunctive to a primary service. CMS has determined that VFA is such a service in
20 relation to DXA and therefore is subject to the new packaging requirement.
- 21 • The new CPT codes and reimbursement rates for DXA and VFA are:
- 22 • 77080: DXA only–\$110.28 (\$99.90 for the technical component and \$10.38 for the
23 professional component)
- 24 • 77085: DXA and VFA performed together–\$115.29 (\$99.90 for the technical component
25 and \$15.39 for the professional component)
- 26 • 77086: VFA performed alone–\$71.37 (\$62.42 for the technical component and \$8.95 for
27 the professional component); and

28
29 Whereas, Of 2018 office reimbursement for the cost of DXA has decreased to about \$30 to \$37;
30 and

31
32 Whereas, The cost of DXA procurement, DXA support and service contract payments and office
33 personnel to perform DXA is about \$150; and

34
35 Whereas, We support H.R. 1898, a bill that would amend title XVIII of the Social Security Act
36 to improve access to, and utilization of, bone mass measurement benefits under part B of the
37 Medicare program by establishing a minimum reimbursement for office-based DXA tests;
38 therefore be it

- 1 RESOLVED, That our American Medical Association advocate for the correction of the
- 2 underpayment by Medicare, Medicaid, and third party payers to medical practices for office-
- 3 based DXA tests. (New HOD Policy)

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

Received: 10/23/18

RELEVANT AMA POLICY

Reimbursement of Screening Bone Densitometry H-425.981

Our AMA: (1) advocates for the use of bone densitometry as an important tool in assessing fracture risk and in the diagnosis of osteoporosis;

(2) advocates that a clinical evaluation accompany any bone mass measurement for the evaluation of fracture risk and osteoporosis;

(3) advocates for the continued participation of the patient's physician in the diagnosis, treatment, and prevention of osteoporosis;

(4) encourages private third party payers to provide coverage for bone mass measurement technology and services for those individuals at high risk of osteoporosis; and

(5) will lobby Congress to add men undergoing testosterone-suppressing treatment for prostate cancer and men who are at high risk for any other reason to the list of beneficiaries receiving Medicare coverage of bone density testing to screen for osteoporosis.

Citation: (CMS Rep. 9, A-99; Appended: Res. 113, I-99; Reaffirmed: CMS Rep. 5, A-09)

References:

Reimbursement for DXA: Interim Final Rule

Effective July 1, 1998, Medicare covers bone densitometry for 5 indications:

1. Estrogen-deficient women at clinical risk for osteoporosis
2. Patients with vertebral abnormalities
3. Patients receiving long-term glucocorticoids (prednisone 7.5 mg/d or more for > 3 m)
4. Patients with primary hyperparathyroidism
5. Patients being monitored to assess the response to an approved drug

NOF Guidelines on BMD Screening

- Women age 65 y and older and men age 70 y and older
- Younger postmenopausal women and men aged 50-69 y about whom you have concern based on their clinical risk factor profile
- Adults who have a fracture after age 50 y
- Adults with a condition or taking a medication associated with low bone mass or bone loss

Clinician's guide to prevention and treatment of osteoporosis. 2010. http://www.nof.org/sites/default/files/pdfs/NOF_ClinicianGuide2009_v7.pdf.

H.R. 1898: To amend title XVIII of the Social Security Act to improve access to, and utilization of, bone mass measurement benefits under part B of the Medicare program by establishing a minimum payment amount under such part for bone mass measurement.

115th CONGRESS

1st Session

H. R. 1898

IN THE HOUSE OF REPRESENTATIVES

April 4, 2017

Mr. Meehan (for himself, Mrs. Blackburn, Mr. Larson of Connecticut, Ms. Sánchez, Mr. Sessions, Mr. Roe of Tennessee, Ms. Moore, Mr. DeFazio, Ms. Pingree, Ms. Norton, Mr. Grijalva, and Mr. McGovern) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to improve access to, and utilization of, bone mass measurement benefits under part B of the Medicare program by establishing a minimum payment amount under such part for bone mass measurement.

1.

Findings

The Congress finds the following:

(1)

Osteoporosis is a major public health problem with 54 million Americans as of 2010 having either low bone mass or osteoporosis, responsible for over 2 million fractures per year, including over 300,000 hip fractures. The estimated total cost of these fractures in 2005 was \$17 billion and expected to rise to over \$25 billion by 2025.

(2)

Osteoporosis is a silent disease that often is not discovered until a fracture occurs. One out of two women and up to one of four men will suffer an osteoporotic fracture in their lifetimes.

(3)

While both men and women may develop osteoporosis, 80 percent are women.

(4)

Most women are not aware of their personal risk factors for osteoporosis, the prevalence of, or the morbidity and mortality associated with the disease, despite the fact that broken bones due to osteoporosis lead to more hospitalizations and greater health care costs than heart attack, stroke, or breast cancer in women age 55 and above.

(5)

A woman's risk of hip fracture is equal to her combined risk of breast, uterine, and ovarian cancer. More women die in the United States in the year following a hip fracture than from breast cancer.

(6)

One out of four people who have an osteoporotic hip fracture will need long-term nursing home care. Half of those who experience osteoporotic hip fractures are unable to walk without assistance.

(7)

Elderly women are so afraid of losing their independence that 8 in 10 would rather die than break their hip and be admitted to a nursing home.

(8)

Bone density testing is more powerful in predicting fractures than cholesterol is in predicting myocardial infarction or blood pressure in predicting stroke.

(9)

Osteoporosis remains both under-recognized and under-treated. Over a 7-year period (2007–2013), 45 percent of older female Medicare beneficiaries had no DXA bone density test, and 25 percent had only one test.

(10)

DXA testing in older women declined in 2014 to the lowest point in 10 years.

(11)

A decade of steady decline in hip fractures stopped abruptly in 2013. Since then, there have been more than 14,000 additional hip fractures, costing over \$560 million, leading to 2,800 more deaths than expected if the decline had continued.

2.

Increasing access to osteoporosis prevention and treatment

Section 1848(b) of the Social Security Act ([42 U.S.C. 1395w-4\(b\)](#))42 U.S.C. 1395w-4(b)[42 U.S.C. 1395w-4\(b\)](#)42 U.S.C. 1395w-4(b)[42 U.S.C. 1395w-4\(b\)](#)) is amended—

(1)

in paragraph (4)(B)—

(A)

by striking and the first 2 months of 2012 and inserting the first 2 months of 2012, 2017, and each subsequent year; and

(B)

by striking paragraph (6) and inserting paragraphs (6) and (12); and

(2)

by adding at the end the following:

(12)

Establishing minimum payment for osteoporosis tests

For dual-energy x-ray absorptiometry services (identified by HCPCS codes 77080 and 77082 and successor codes 77085 and 77086 (and any succeeding codes)) furnished during 2017 or a subsequent year, the Secretary shall establish a national minimum payment amount under this subsection—

(A)

for such services identified by HCPCS code 77080, equal to \$98 (with national minimum payment amounts of \$87.11 for the technical component and \$10.89 for the professional component);

(B)

for such services identified by HCPCS code 77086, equal to \$35 (with national minimum payment amounts of \$27.18 for the technical component and \$7.82 for the professional component); and

(C)

for the bundled code for dual energy absorptiometry and vertebral fracture assessment studies identified as HCPCS code 77085, equal to \$133 (with national minimum payment amounts of \$114.29 for the technical component and \$18.71 for the professional component).

Such minimum payment amounts shall be adjusted by the geographical adjustment factor established under subsection (e)(2) for the services for the respective year.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 823
(I-18)

Introduced by: Georgia
Subject: Medicare Cuts to Radiology Imaging
Referred to: Reference Committee J
(Steven Chen, MD, Chair)

- 1 Whereas, Medicare office imaging reimbursement is below facility-based imaging on a regular
2 basis and has now extended into payment for digital radiography; and
3
4 Whereas, As part of a push to nudge U.S. healthcare providers to adopt digital radiography
5 (DR), the Medicare system reduced payments for exams performed on analog x-ray systems,
6 those using film, by 20% starting in 2017; and
7
8 Whereas, In 2018, sites using computed radiography (CR) equipment (cassette based) but not
9 DR had payment reductions; and
10
11 Whereas, Starting in 2018, payments for imaging studies performed on CR equipment were
12 reduced by 7% for the next five years, and 10% after that; and
13
14 Whereas, Digital radiology (DR) payment is not reduced at all; and
15
16 Whereas, The cost to upgrade to DR from CR is substantial; and
17
18 Whereas, The image quality of CR and DR are comparable; and
19
20 Whereas, Facility radiology systems can afford to upgrade to DR financially more easily than
21 small offices; therefore be it
22
23 RESOLVED, That our American Medical Association advocate for elimination of the Medicare
24 differential imaging payments for small practices versus facility payments (New HOD Policy);
25 and be it further
26
27 RESOLVED, That our AMA advocate for elimination of the Medicare computed radiography
28 (CR) payment reductions. (New HOD Policy)

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

Received: 10/23/18

RELEVANT AMA POLICY

Parity in Medicare Reimbursement D-390.969

Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the reductions in Medicare payment for imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005; (2) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (3) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing.

Citation: BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-08;
Modified: BOT Rep. 09, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 826
(I-18)

Introduced by: Resident and Fellow Section

Subject: Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

-
- 1 Whereas, Our AMA vigorously opposes any unfunded mandates on physicians; and
2
3 Whereas, Our AMA supports improving health outcomes and decreasing cost of treating the
4 chronically homeless through high quality, cost-effective approaches; and
5
6 Whereas, California recently passed SB 1152, a piece of legislation that requires hospitals to,
7 among other things, only discharge homeless patients to a “safe and appropriate location”,
8 provide transportation to said location, and offer appropriate clothing upon discharge¹; and
9
10 Whereas, This law is set to take effect on July 1, 2019 without provisions for funding; therefore
11 be it
12
13 RESOLVED, That our American Medical Association work with relevant stakeholders in
14 developing sustainable plans for the appropriate discharge of chronically-homeless patients
15 from hospitals (Directive to Take Action); and be it further
16
17 RESOLVED, That our AMA reaffirm H-270.962 and H-130.940. (Reaffirm HOD Policy)
18
19 Fiscal note: Modest: Between \$1,000 - \$5,000.
20
21 Received: 11/10/18

References:

1. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB1152

Relevant AMA Policy:

H-130.940 Emergency Department Boarding and Crowding

Our AMA:

1. congratulates the American College of Emergency Physicians for developing and promulgating solutions to the problem of emergency department boarding and crowding;
2. supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding;
3. supports dissemination of best practices in reducing emergency department boarding and crowding;
4. continues to encourage entities engaged in measuring emergency department performance (e.g., payers, licensing bodies, health systems) to use evidence-based, clinical performance measures that enable clinical quality improvement and capture variation such as those

developed by the profession through the Physician Consortium for Performance Improvement;
5. continues to support physician and hospital use and reporting of emergency medicine performance measures developed by the Physician Consortium for Performance Improvement;
and

6. continues to support the harmonization of individual physician, team-based, and facility emergency medicine performance metrics so there is consistency in evaluation, methodology, and limited burden associated with measurement.

[CMS Rep. 3, A-09]

H-160.903 Eradicating Homelessness

Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis; (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; and (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

[Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18]

H-270.962 Unfunded Mandates

Our AMA vigorously opposes any unfunded mandates on physicians. [Res. 217, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmation A-16]

Reference Committee K

BOT Report(s)

12 Information Regarding Animal-Derived Medications

CSAPH Report(s)

01* Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals

02* FDA Expedited Review Programs and Processes

Resolution(s)

901 Support for Preregistration in Biomedical Research

902 Increasing Patient Access to Sexual Assault Nurse Examiners

903 Regulating Front-of-Package Labels on Food Products

904 Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service

905 Support Offering HIV Post Exposure Prophylaxis to all Survivors of Sexual Assault

906 Increased Access to Identification Cards for the Homeless Population

908 Increasing Accessibility to Incontinence Products

911 Regulating Tattoo and Permanent Makeup Inks

912 Comprehensive Breast Cancer Treatment

913 Addressing the Public Health Implications of Pornography

914 Common Sense Strategy for Tobacco Control and Harm Reduction

915* Mandatory Reporting

916* Ban on Tobacco Flavoring Agents with Respiratory Toxicity

917* Protect and Maintain the Clean Air Act

918* Allergen Labeling on Food Packaging

919* Opioid Mitigation

920* Continued Support for Federal Vaccination Funding

921* Food Environments and Challenges Accessing Healthy Food

922# Full Information on Generic Drugs

923# Scoring of Medication Pills

924# Utilizing Blood from "Therapeutic" Donations

926# E-Cigarettes, Revisited

* contained in the Handbook Addendum

contained in the Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 922
(I-18)

Introduced by: Georgia
Subject: Full Information on Generic Drugs
Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, There is no longer a U.S. Food and Drug Administration (FDA) requirement that the
2 generic drug needs to be tested in patients: just 24 – 36 adult volunteers! Patient testing was
3 abandoned in 1984; and
4
5 Whereas, While New Drug Applications (NDA) to the FDA require patient testing, generic drugs
6 are considered under Abbreviated New Drug Applications (ANDA) and no patient testing is
7 required; and
8
9 Whereas, Current FDA protocol allows generic drugs to be marketed after having met the
10 criteria for bioequivalence to brand-name drugs; and
11
12 Whereas, The generic drug product must have “data demonstrating that the drug product is
13 bioequivalent to the pioneer (innovator = AKA Brand Product) drug product;” and
14
15 Whereas, The active ingredient is tested using PK measurements that are performed and
16 include area under the plasma concentration-time curve (AUC) and the maximum or peak drug
17 concentrations (Cmax). If there is a difference of greater than 20% for each of the tests, then
18 this is determined to be significant and thus undesirable. This is expressed as a limit of each of
19 these two tests of 80% and by convention that all of the data is expressed as a ratio of the
20 average response (AUC and Cmax) and the limit for the second statistical test is 125%
21 (reciprocal of 80%); and
22
23 Whereas, The FDA feels that bioequivalent products and therapeutically equivalent products
24 can be substituted for each other without any adjustment in dose. ANDA drugs brought to
25 market are compared to the innovator drug, but one generic is not compared to another generic;
26 and
27
28 Whereas, Two generic drugs – both classified by the FDA as bioequivalent to the brand-name
29 drug – can be significantly different while still falling within the FDA’s specified range for
30 bioequivalence; thus, demonstrating concern over whether the two drugs should be deemed
31 therapeutically different¹; and
32
33 Whereas, The data collected at the FDA compares generic substitution of generic X or generic
34 Y versus Brand Name but does not compare Generic X versus Generic Y. Clinically physicians
35 are often substituting Generic X for Generic Y and have no scientific data to compare these
36 two¹; therefore be it

- 1 RESOLVED, That our American Medical Association advocate that generic drugs have an FDA-
- 2 approved package insert available when dispensed that discloses active and inactive
- 3 ingredients and clear language with bio-equivalent data as compared to parent branded drug.
- 4 (New HOD Policy)

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

Received: 10/23/18

RELEVANT AMA POLICY

Generic Drugs H-125.984

Our AMA believes that: (1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.

(2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.

(3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.

(4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.

(5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.

(6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).

(7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process.

Citation: (CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmation A-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 525, A-10; Reaffirmed in lieu of Res. 224, I-14)

Prescription Labeling H-115.974

Our AMA recommends (1) That when a physician desires to prescribe a brand name drug product, he or she do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, he or she do so by designating the USAN-assigned generic name of the drug on the prescription.

(2) That, except where the prescribing physician has indicated otherwise, the pharmacist should include the following information on the label affixed to the container in which a prescription drug is dispensed: in the absence of product substitution, (a) the brand and generic name of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; and (d) the name of the manufacturer or distributor.

(3) When generic substitution occurs: (a) the generic name (or, when applicable, the brand name of the generic substitute ["branded" generic name]) of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; (d) the manufacturer or distributor; and (e) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]".

(4) When a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: (a) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; (b) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug container with the name of the new generic drug manufacturer or distributor and, show this to the patient; (c) affix to the primary label an auxiliary (sticker) label that states, "This is the same medication you have been getting. Color, size, or shape may appear different;" and (d) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed.

Citation: BOT Rep. 1, A-95; Amended: CSA Rep. 2, I-99; Modified Res. 512, I-00; Reaffirmed: CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmed: Sub. Res. 509, A-07; Reaffirmed: CSAPH Rep. 01, A-17

References

¹Information and the following supporting figure reprinted by permission of American College of Rheumatology:

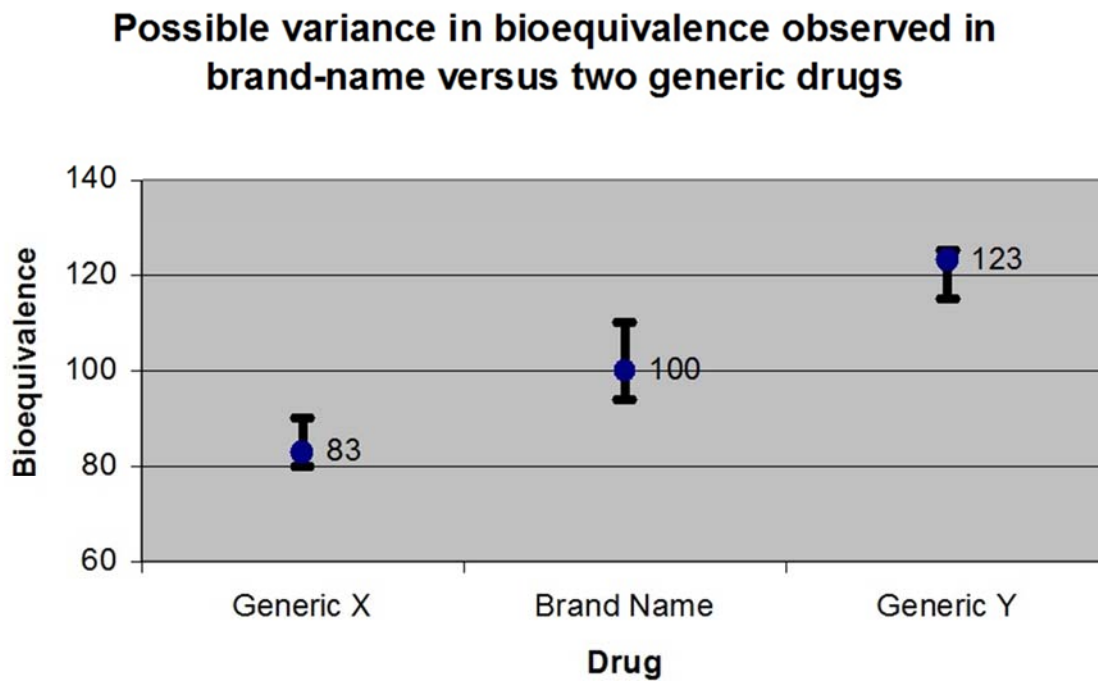


Figure 1: Possible variance in bioequivalence observed in brand-name versus two generic drugs

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 923
(I-18)

Introduced by: Georgia
Subject: Scoring of Medication Pills
Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Cost of medications is important for the care of patients; and
2
3 Whereas, Many patients do not fill medications due their cost; and
4
5 Whereas, The health of patients is in part dependent on the ability of the patient to continue
6 their medication program; and
7
8 Whereas, The cost often precludes the ability of achieving improved health; and
9
10 Whereas, The cost of brand vs generic medication can be decreased by the ability of the patient
11 to cut higher dose pills prescribed to meet their medication dose requirement; and
12
13 Whereas, Cutting a larger dose pill can allow the patient to adjust the dose requirement
14 prescribed by their physician at a lower cost to the patient, requiring less payment due to fewer
15 pills disbursed; therefore be it
16
17 **RESOLVED**, That our American Medical Association advocate that the U.S. Food and Drug
18 Administration require scoring of all tablets and pills depending on their composition, so that the
19 patient may be able to dose adjust their medication number requirement as prescribed by their
20 physician at a lower cost to the patient. (New HOD Policy)

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

Received: 10/23/18

RELEVANT AMA POLICY

Medication Scoring H-115.973

Our AMA: (1) recommends to pharmaceutical manufacturers that, when appropriate, tablets be scored on both sides and so constructed that they will more readily divide in half and not fragment upon attempts at division; and (2) opposes third party policies that mandate the use of pill-splitting or pill-breaking to reduce pharmaceutical or healthcare costs without proper input from the pharmaceutical manufacturers and practicing physicians.

Citation: (Res. 510, A-95; Appended: Sub. Res. 513, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 924
(I-18)

Introduced by: Georgia
Subject: Utilizing Blood from “Therapeutic” Donations
Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

1 Whereas, Hemochromatosis, a chronic iron overload condition, is the most common genetic
2 disorder found in the U.S.¹; and
3
4 Whereas, The treatment for hemochromatosis involves routine phlebotomies once a hematocrit
5 reaches above 45%, to prevent excessive iron deposition into organs such as the liver,
6 pancreas, and the heart¹; and
7
8 Whereas, The withdrawn blood is for “therapeutic” purposes and can only be donated to a
9 limited number of organizations², becoming waste product. The lack of having to pay a copay is
10 considered a “financial incentive” by the Red Cross, thus they do not accept blood from these
11 donors, despite facing blood shortages³; and
12
13 Whereas, This iron-rich blood could be utilized for hemorrhage control during traumas or
14 provided to individuals who present with one of the many causes of anemia, locally and
15 worldwide; therefore be it
16
17 RESOLVED, That our American Medical Association advocate for the Centers for Medicare and
18 Medicaid Services to engage in dialogue with the Red Cross to reanalyze their donor eligibility
19 criteria, to accept blood from a broader category of individuals, including but not limited to
20 hereditary hemochromatosis. (New HOD Policy)

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

Received: 10/23/18

¹ NIH Hemochromatosis Information; <https://ghr.nlm.nih.gov/condition/hereditary-hemochromatosis#statistics>

² Acceptable centers for receiving blood from patients with Hemachromatosis.

<https://www.fda.gov/BiologicsBloodVaccines/BloodBloodProducts/RegulationoftheBloodSupply/Variations/ucm164649.htm>

³ Red Cross, <http://www.redcross.org/news/press-release/Emergency-need-for-blood-donations-as-Red-Cross-experiences-critical-blood-shortage>

RELEVANT AMA POLICY

Use of Blood Therapeutically Drawn from Hemochromatosis Patients H-50.979

Our AMA: (1) encourages physicians to explain to their patients that hereditary hemochromatosis (HH) has a genetic basis, that the disease is not transmissible via blood transfusions, and that the blood from persons with HH is not necessarily unsuitable for direct transfusion; and (2) recommends against the unlabeled use for direct transfusion of blood drawn therapeutically from persons with hereditary hemochromatosis (HH) until a means to ensure their altruistic intent is available, such as when therapeutic phlebotomies are available at no charge to persons requiring them.

Citation: (CSA Rep. 1, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 926
(I-18)

Introduced by: Organized Medical Staff Section

Subject: E-Cigarettes, Revisited

Referred to: Reference Committee K
(Darlyne Menscer, Chair)

- 1 Whereas, Research shows that the use of e-cigarettes and vaping products is unsafe and can
2 cause addiction; and
3
4 Whereas, As the popularity of e-cigarettes and vaping continues to grow among our youth, it is
5 vital for the American Medical Association to recognize that the use of such nicotine products is
6 an urgent public health crisis; and
7
8 Whereas, The AMA must take a more proactive approach in support of anti-tobacco efforts to
9 improve the health of our nation's youth, including but not limited to urging the federal
10 government to support anti-tobacco legislation prohibiting smoking on public transportation and
11 calling on tobacco companies to stop targeting children in their advertising campaigns; therefore
12 be it
13
14 RESOLVED, That our American Medical Association recognize the use of e-cigarettes and
15 vaping as an urgent public health crisis and actively work with the Food and Drug Administration
16 and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and
17 vaping devices, including but not limited to bans and strict restrictions on marketing to minors
18 under the age of 21. (Directive to Take Action)

Fiscal note: Modest: Between \$1,000 - \$5,000.

Received: 11/10/2018

Not for consideration

Resolutions not for consideration

- 601 Creation of an AMA Election Reform Committee
- 602* AMA Policy Statement with Editorials
- 824# Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs
- 825# Preservation of the Patient-Physician Relationship
- 907 Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing
- 909 Use of Person-Centered Language
- 910 Shade Structures in Public and Private Planning and Zoning Matters
- 925# Eliminating the Death Toll from Combustible Cigarettes

* contained in the Handbook Addendum

contained in the Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 824
(I-18)

Introduced by: Organized Medical Staff Section

Subject: Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs

Referred to: Reference Committee J
(Steven Chen, Chair)

1 Whereas, The performance analysis results for Medicare Shared Savings Accountable Care
2 Organizations (ACOs) show lower savings for hospital integrated systems as opposed to
3 physician-owned systems; and
4
5 Whereas, The system infrastructure costs needed to form ACOs have resulted in many
6 physician practices being taken over and consolidated by hospital-owned systems; and
7
8 Whereas, The fact that hospital integrated systems generated lower savings or even higher
9 costs compared to those savings realized by physician-owned groups is a major concern; and
10
11 Whereas, CMS is advocating for ACOs to move to the Next Generation model by taking on
12 downside risk as the major route to participate in alternative payment models; and
13
14 Whereas, This will be attempted in an environment where the savings of hospital integrated
15 systems are not financially significant—placing physicians in those systems at increased risk for
16 practice failure or loss of their positions through compensatory staff reductions; and
17
18 Whereas, The majority of Medicare Shared Savings Program ACOs have decided not to move
19 to the Next Generation model based upon the aforementioned economic inadequacies; and
20
21 Whereas, Hospital integrated systems that have failed to generate significant savings are under
22 pressure to either downsize medical staffs or take over the involved health care system entirely,
23 leading to further consolidation—an even worse scenario driven in some situations by financial
24 entities with no previous commitment to, or involvement in, medicine; and
25
26 Whereas, Efforts to downsize the medical staff are not only demoralizing, but may also diminish
27 the medical staff's governance functions with each subsequent consolidation—an effect that is
28 most extreme among the physicians involved in hospital integrated systems; therefore be it
29
30 RESOLVED, That our American Medical Association study: (1) the effect of hospital integrated
31 system ACOs' failure to generate savings on downsizing of the medical staff and further
32 consolidation of medical practices; and (2) the root causes for failure to generate savings in
33 hospital integrated ACOs, as compared to physician-owned ACOs, and report back at the 2019
34 Interim Meeting. (Directive to Take Action)

Fiscal note: Modest: Between \$1,000 - \$5,000.

Received: 11/10/2018

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 825
(1-18)

Introduced by: Organized Medical Staff Section
Subject: Preservation of the Patient-Physician Relationship
Referred to: Reference Committee J
(Steven Chen, Chair)

1 Whereas, The patient-physician relationship is among the most important elements of our
2 medical profession; and
3
4 Whereas, The quality of the patient-physician relationship is crucial to the care of the patient,
5 improving the value of the patient-physician encounter to both parties and greatly enhancing the
6 chances that the patient's concern can be met; and
7
8 Whereas, Dr. Bernard Lown, in his book "The Lost Art of Healing: Practicing Compassion in
9 Medicine" states that "the three thousand year tradition which bonded doctor and patient in a
10 special affinity of trust is being traded for a new type of relationship; healing is replaced with
11 treating, caring is supplanted by managing, and the art of listening is taken over by technology;"
12 and
13
14 Whereas, Dr. Lown's observations are more relevant now than ever before as a result of: (1)
15 increasing time constraints on physicians due to scheduling issues; (2) the intrusion of
16 electronic devices in the consultation room, which can make sustained eye contact between the
17 patient and his/her physician more challenging; and (3) curriculum changes in some medical
18 schools such that history-taking and examination skills are not emphasized as they once were;
19 and
20
21 Whereas, As physicians, we owe it to our patients and ourselves to do everything we can to
22 preserve the patient-physician relationship; therefore be it
23
24 RESOLVED, That our American Medical Association, in an effort to improve professional
25 satisfaction among physicians while also enhancing patient care, conduct a study to identify
26 perceived barriers to optimal patient-physician communication from the perspective of both the
27 patient and the physician, as well as identify healthcare work environment factors that impact a
28 physician's ability to deliver high quality patient care, including but not limited to: (1) the use
29 versus non-use of electronic devices during the clinical encounter; and (2) the presence or
30 absence of a scribe during the patient-physician encounter, and report back at the 2020 Interim
31 Meeting.

Fiscal note: Modest: Between \$1,000 - \$5,000.

Received: 11/10/2018

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 925
(I-18)

Introduced by: Washington

Subject: Eliminating the Death Toll from Combustible Cigarettes

Referred to: Reference Committee K
(Darlyne Menscer, MD, Chair)

- 1 Whereas, The United States has made great progress in decreasing cigarette smoking since
2 the first Surgeon General's report in 1964; and
3
4 Whereas, Combustible cigarettes continue to kill between 450,000 and 500,000 people each
5 year in the United States; and
6
7 Whereas, The death toll from all other forms of nicotine is very small and not statistically
8 measurable; and
9
10 Whereas, There are many other nicotine-delivering products available to U.S. consumers; and
11
12 Whereas, The level of measurable toxins in non-combustible nicotine products is much lower
13 than in combustible products; and
14
15 Whereas, Safety concerns (real or imagined) have inhibited smokers' understanding of the
16 benefits of product switching; and
17
18 Whereas, Wise regulation and medically accurate labeling can address safety concerns about
19 non-combustible nicotine products; therefore be it
20
21 RESOLVED, That our American Medical Association study and report on the conditions under
22 which our country could successfully eliminate the manufacture, distribution, and sale of
23 combustible cigarettes at the earliest feasible date. (Directive to Take Action)

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

Received: 10/19/18

RELEVANT AMA POLICY

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

H-495.986 Tobacco Product Sales and Distribution

Our AMA: (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems ((ENDS)) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (2) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; (3) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (4) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (5) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (6) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (7) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; (8) opposes the sale of tobacco at any facility where health services are provided; and (9) supports that the sale of tobacco products be restricted to tobacco specialty stores.

CSA Rep. 3, A-04 Appended: Res. 413, A-04 Reaffirmation A-07 Amended: Res. 817, I-07 Reaffirmation A-08 Reaffirmation I-08 Reaffirmation A-09 Reaffirmation I-13 Reaffirmation A-14 Reaffirmation I-14 Reaffirmation A-15 Modified in lieu of Res. 421, A-15 Modified in lieu of Res. 424, A-15 Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Robert D. Allaben, MD

Introduced by Michigan

Whereas, Robert D. Allaben, MD, a surgeon and teacher of medicine, was born on September 26, 1930, and passed away on March 15, 2018; and

Whereas, Doctor Allaben dedicated his life to his patients, his family, and the improvement of medicine; and

Whereas, Doctor Allaben was on staff at various Detroit hospitals and retired as Chief of Surgery for Grace Hospital; and

Whereas, Doctor Allaben was one of the first kidney transplant surgeons in Michigan and served as president of the Transplant Society of Michigan (Gift of Life Michigan); and

Whereas, Doctor Allaben was involved as a member and leader in numerous medical professional associations including the Michigan State Medical Society, serving as Vice-Speaker and Speaker of the House from 1988-1993, the American College of Surgeons, and the American Medical Association; and

Whereas, Doctor Allaben was a member of the Michigan Delegation to the AMA House of Delegates; and

Whereas, Doctor Allaben was a leader, mentor, and motivator to many; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize and honor Robert D. Allaben, MD, for his exceptional service to the practice of medicine and his patients; and be it further

RESOLVED, That our American Medical Association House of Delegates extend its deepest sympathy to the family members of Robert D. Allaben, MD.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Joseph D. Babb, MD

Introduced by the American College of Cardiology, American Society of Echocardiography, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions

Whereas, Dr. Joseph D. Babb was a distinguished interventional cardiologist, advocate for patients, and leader in cardiovascular medicine; and

Whereas, Dr. Babb was a Captain of the United States Army Medical Corp serving in both Vietnam and at Walter Reed Medical Center; and

Whereas, Dr. Babb after completing training in internal medicine and cardiology at Massachusetts General Hospital was assistant professor of Medicine and Cardiology at the Pennsylvania State University Hershey Medical Center, was the Chief of Cardiology at The Bridgeport Hospital, and was the Director of the Cardiac Catheterization Laboratories at East Carolina University Brody School of Medicine; and

Whereas, Dr. Babb performed the first ever coronary angioplasty in the state of Connecticut in 1981; and

Whereas, Dr. Babb was a tireless patient and physician advocate having served as the President of the Society of Cardiovascular Angiography and Intervention (SCAI) from 2001-2002 and having received the SCAI Distinguished Service Award in 2005; and

Whereas, Dr. Babb previously served as the American College of Cardiology Governor of both Connecticut and North Carolina where he was instrumental in founding the North Carolina Regional Approach to Cardiovascular Emergencies project, which created a statewide system for providing rapid care for patients with ST-elevation myocardial infarction; and

Whereas, Dr. Babb headed SCAI's Continuing Medical Education Committee which led to the Societies' earning status for the Accreditation Council for Continuing Medical Education, and through his position he worked to develop guidelines for SCAI to ensure that the education of interventional cardiologists is performed in the most unbiased, objective, and patient focused manner possible; and

Whereas, Dr. Babb was beloved by patients and colleagues leading to his being named the 'Patient Preferred Interventional Cardiologist' in the state of North Carolina earlier this year; and

Whereas, Dr. Babb was instrumental in helping SCAI obtain a delegate seat in the AMA House of Delegates, serving as representative in the Specialty and Service Society since 2007 and as a delegate to our AMA House of Delegates since 2012; and

Whereas, Dr. Babb passed away suddenly on September 6th 2018; therefore be it

RESOLVED, That our American Medical Association House of Delegates acknowledge Dr. Joseph D. Babb's lifelong devotion to patient care, advocacy, and clinician education; and be it further

RESOLVED, That our AMA extend heartfelt condolences to Dr. Babb's wife Margo as well as his children and grandchildren.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

R. Jack Chase, MD

Introduced by Michigan

Whereas, R. Jack Chase, MD, a physician in Internal Medicine, was born on July 24, 1922, and passed away on March 3, 2017; and

Whereas, Doctor Chase served our country proudly and honorably with the U.S. Navy during World War II from 1943 to 1947 and then again during the Korean War; and

Whereas, Doctor Chase was born in Grand Rapids, Michigan, and chose to establish his internal medicine practice there; and

Whereas, Doctor Chase cared for his patients with skill and compassion for 38 years; and

Whereas, Doctor Chase led by example and tirelessly served his profession and his community; serving on numerous boards including the Butterworth Foundation, Kent County Board of Health, Kent Medical Foundation, United Way of Kent County, Kent County Medical Society, Michigan Doctors Political Action Committee, Michigan State Medical Society, Cherry Street Health Organization, Clark Retirement Community, and Clark Foundation; and

Whereas, Doctor Chase was a past president of the Kent County Medical Society; and

Whereas, Doctor Chase served as a delegate to the Michigan State Medical Society and the American Medical Association House of Delegates; and

Whereas, Doctor Chase was honored with membership into the Distinguished Physicians Society of Spectrum Health; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize and honor R. Jack Chase, MD, for his outstanding contributions to the countless citizens whose lives were touched by his service to country, community, and profession; and be it further

RESOLVED, That our American Medical Association House of Delegates extend its deepest sympathy to the family members of R. Jack Chase, MD.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Dorothy M. Kahkonen, MD

Introduced by Michigan

Whereas, Dorothy M. Kahkonen, MD, a physician in Endocrinology and Metabolism, was born January 23, 1941, and passed away on February 24, 2018; and

Whereas, Doctor Kahkonen was a tireless supporter of the medical community in Michigan for more than 50 years; and

Whereas, Doctor Kahkonen was raised in Michigan and spent the entirety of her career at Henry Ford Hospital where she served as Head of the Division of Endocrinology and Metabolism from 1996 until her retirement in 2006; and

Whereas, Doctor Kahkonen was known for her outstanding clinician educator and clinical research activities, as well as superb leadership abilities; and

Whereas, Doctor Kahkonen utilized her knowledge and leadership attributes to advance her profession, advocate for her patients, and serve organized medicine in a variety of roles; and

Whereas, Doctor Kahkonen was a member of the Michigan State Medical Society (MSMS) Board of Directors, MSMS President in 2002, Speaker of the MSMS House of Delegates from 1996-2001, Vice-Speaker of the MSMS House of Delegates from 1993-1996, member of the MSMS Legislative, Continuing Medical Education, and Annual Scientific Planning Committees, and, most recently, President of the MSMS Foundation; and

Whereas, Doctor Kahkonen served with distinction and dedication on the Michigan Delegation to the American Medical Association for many years; and

Whereas, Doctor Kahkonen was also a member of the American Diabetes Association, American College of Physicians, and American Heart Association Council on Arteriosclerosis; and

Whereas, Doctor Kahkonen had an illustrious career and received many accolades including a lectureship created in her name, special recognition for "Leadership and Untiring Dedication" by the Wayne County Medical Society of Southeast Michigan, and the Professional Achievement Award by the Wayne County Medical Society; and

Whereas, Doctor Kahkonen was a tireless physician and gave generously of her time; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize and honor Dorothy M. Kahkonen, MD, for her outstanding service to the profession of medicine and the countless patients whose lives were touched by her hard work and dedication, and be it further

RESOLVED, That our American Medical Association House of Delegates extend its deepest sympathy to the family members of Dorothy M. Kahkonen, MD.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Hugh Lamensdorf, MD

Introduced by Texas

Whereas, On October 26, 2018, our American Medical Association, the Texas Medical Association and the Tarrant County Medical Society were saddened by the death of Hugh Lamensdorf, MD; and

Whereas, Dr. Lamensdorf, a urologist, worked tirelessly during his long career to represent his colleagues and patients in establishing the policies of medicine; was a leader of organized medicine on the local, state, and national levels, serving as president of the Texas Medical Association and delegate to the American Medical Association; and

Whereas, Dr. Lamensdorf, delivered medical care to returning Vietnam soldiers as a captain in the United States Air Force at Carswell Air Force Base; and

Whereas, Dr. Lamensdorf was recognized by his peers for his medical expertise by being inducted into the American College of Surgeons and The International Urologic Association (Internationale d' Urologie), and becoming a clinical professor of surgery at The University of Texas Southwestern Medical School; and

Whereas, Dr. Lamensdorf served as president of Congregation Beth-El, on the Board of Directors of the Fort Worth's Historic Southside that led to the successful Magnolia Avenue revival, and on the Board of Directors of the Presbyterian Night Shelter; therefore be it

RESOLVED, That our American Medical Association extend its deepest sympathy to the family members of Hugh Lamensdorf, MD; and be it further

RESOLVED, That our AMA House of Delegates adopt this resolution as an indication of the respect organized medicine held for Hugh Lamensdorf, MD, as a physician, civic leader, and servant of humanity.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Richard J. McMurray, MD

Introduced by Michigan

Whereas, Richard J. McMurray, MD, was born on September 9, 1922, and passed away on January 27, 2018; and

Whereas, Doctor McMurray, prior to becoming a physician, served our country in the south Pacific during World War II; and

Whereas, Doctor McMurray dedicated his life to his patients, profession, family, and community; and

Whereas, Doctor McMurray, an obstetrician-gynecologist, started his practice in Flint, Michigan; and

Whereas, Doctor McMurray practiced medicine for 37 years, helping to bring around 5,000 babies into the world; and

Whereas, Doctor McMurray served as Chief of Obstetrics and a member of the Executive Committee at McLaren Hospital in Flint, and was a member of the teaching staff at Hurley Medical Center; and

Whereas, Doctor McMurray was also committed to advancing the practice of medicine through physician and patient advocacy organizations; and

Whereas, Doctor McMurray was President of both the Genesee County Medical Society and the Michigan State Medical Society, as well as serving on the Board of Blue Cross Blue Shield of Michigan; and

Whereas, Doctor McMurray was active with the American Medical Association as a member of the Michigan Delegation to the AMA and as the Chair of the AMA's Council on Ethical and Judicial Affairs; and

Whereas, Doctor McMurray was a leader and mentor, and loved by many of his patients; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the lifelong service of Richard J. McMurray, MD, to his community, patients, and profession; and be it further

RESOLVED, That our American Medical Association House of Delegates extend its deepest sympathy to the family members of Richard J. McMurray, MD.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Joseph W Sokolowski, Jr., MD

Introduced by the American Thoracic Society; American Academy of Allergy, Asthma and Immunology; American Academy of Sleep Medicine; American College of Allergy, Asthma and Immunology; Society of Critical Care Medicine; New Jersey; American College of Chest Physicians

Whereas, Joseph W. Sokolowski Jr., MD, was born December 12, 1936 and passed away on December 31, 2017; and

Whereas, Dr Sokolowski was a physician trained at the College of the Holy Cross and the Jefferson Medical College graduating in 1962; and

Whereas, Dr. Sokolowski served in the U.S. Navy on active duty from 1962 to 1971 as Captain and continued as a reserve officer until 1985 including serving as the Chief Medical Officer on the USS Fulton; and

Whereas, Dr. Sokolowski practiced pulmonary medicine and was chair of the Pulmonary Division and Director of Respiratory Care at Our Lady of Lourdes Medical Center; and

Whereas, Dr. Sokolowski was Emeritus Clinical Professor of Medicine at Thomas Jefferson University and was President of the Jefferson Medical College Alumni Association; and

Whereas, Dr. Sokolowski served on the Board of Trustees of the American Thoracic Society and represented that society as the Delegate to the AMA; and

Whereas, Dr. Sokolowski was an active member of the Chest-Allergy Caucus and the Speciality and Service Society of the AMA; and

Whereas, Dr. Sokolowski had lifelong dedication to medical service thru the Knights of Malta including several missions to Haiti and Lourdes, France; and

Whereas, Dr. Sokolowski continued his dedication to medical service in retirement as a volunteer emergency medical technician in his community; and

Whereas, Dr Sokolowski is survived by his wife of 54 years, Maureen, and they had 9 children including one who predeceased him as well as 19 grandchildren; and

Whereas, Dr. Sokolowski was a lifetime member of the AMA; and

Whereas, Dr. Sokolowski was President of the Camden County Medical Society; and

Whereas, Dr. Sokolowski was a founding member of the Medical Review and Certification Council of New Jersey and the President of the National Association for Medical Direction of Respiratory Care; and

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

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

RESOLVED, That our AMA extend its sympathy to the family of Dr. Sokolowski and present them with a copy of this resolution.