

**AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

**72<sup>nd</sup> INTERIM MEETING  
National Harbor, Maryland  
November 10–13, 2018**

**CALL TO ORDER AND MISCELLANEOUS BUSINESS**

**CALL TO ORDER:** The House of Delegates convened its 72<sup>nd</sup> Interim Meeting at 2 p.m. on Saturday, Nov. 10, in the Maryland Ballroom of the Gaylord National Resort and Convention Center in National Harbor, Maryland, Susan R. Bailey, MD, Speaker of the House of Delegates, presiding. The Sunday, Nov. 11, Monday, Nov. 12, and Tuesday, Nov. 13 sessions also convened in the Maryland Ballroom. The meeting adjourned following the Tuesday morning session.

**INVOCATION:** The following invocation was delivered by Linda G. Fischer, an Episcopal lay woman and a chaplain in Palliative Care at MedStar Washington Hospital Center.

Spirit of Compassion. Infinite Source of all Wisdom, Healing, and Peace. God of 10,000 Names: We stand before you in this moment with grateful hearts for the sheer gift of life and breath in the body; in gratitude for the love of family and friends; for the gift of home and country, and for the sacrifice of those who protect our freedom. We are grateful also for the privilege of having been given meaningful work to do, both at the bedside, as well as here, today, in the work that lies before you. Now, may Divine Wisdom open the door of your creative imagination, sharpen your intellect, inspire your heart, and strengthen your resolve to work for the good of all people, in the service of making health care whole. This we pray, O God, not knowing our need but trusting in you.

Amen. Amen. Amen.

**AWARDS:** The following awards were presented during the opening session on Saturday, Nov. 10.

- Medal of Valor – C. Ray Callas, MD, from Beaumont, Texas for his efforts during Hurricane Harvey.
- American Medical Association Foundation Award for Health Education – Francisco G Cigarroa, MD, from San Antonio, Texas for his work in developing medical schools in underserved areas.

Medical Executive Lifetime Achievement Awards were presented to the following individuals:

- R. Gregory Bernica, chief executive officer of the Harris County Texas Medical Society;
- Alfred Gilchrist, chief executive officer of the Colorado Medical Society;
- Susan Hogeland, executive vice president of the California Academy of Family Physicians;
- Stuart Samuel Friedman, former executive director of the Suffolk County New York Medical Society;
- Paul S. Sanders, MD, former chief executive officer of the Minnesota Medical Association; and
- Gordon H. Smith, executive vice president of the Maine Medical Society.

**REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS:** The following reports were presented by David Walsworth, MD, Chair:

**CREDENTIALS:** The Committee on Rules and Credentials reported that on Saturday, Nov 10, 533 out of 617 delegates (86.4%) had been accredited, thus constituting a quorum; on Sunday, Nov. 11, 559 delegates (90.6%) were present; on Monday, Nov. 12, 580 (94.0%) were present; and on Tuesday, Nov. 13 582 (94.3%) were present.

**RULES REPORT – Saturday, November 10****HOUSE ACTION: ADOPTED**

Your Committee on Rules and Credentials recommends:

1. **House Security**  
Maximum security shall be maintained at all times to prevent disruptions of the House, and only those individuals who have been properly badged will be permitted to attend.
2. **Credentials**  
The registration record of the Committee on Rules and Credentials shall constitute the official roll call at each meeting of the House.
3. **Order of Business**  
The order of business as published in the Handbook shall be the official order of business for all sessions of the House of Delegates. This may be varied by the Speaker if, in her judgment, it will expedite the business of the House, subject to any objection sustained by the House.
4. **Privilege of the Floor**  
The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House.
5. **Procedures of the House of Delegates**  
The November 2018 edition of the “House of Delegates Reference Manual: Procedures, Policies and Practices” shall be the official method of procedure in handling and conducting the business before the AMA House of Delegates.
6. **Limitation on Debate**  
There will be a 2-minute limitation on debate per presentation subject to waiver by the Speaker for just cause.
7. **Conflict of Interest**  
Members of the House of Delegates who have a substantial financial interest in a commercial enterprise, which interest will be materially affected by a matter before the House of Delegates, must publicly disclose that interest before testifying at a reference committee on the matter or speaking on the floor of the House of Delegates on the matter.
8. **Conduct of Business by the House of Delegates**  
Each member of the House of Delegates and the AMA Officers resolutely affirm a commitment to be courteous, respectful and collegial in the conduct of House of Delegates actions, characteristics which should exemplify the members of our respected and learned profession.
9. **Respectful Behavior**  
Courteous and respectful dealings in all interactions with others, including delegates, AMA and Federation staff, and other parties, are expected of all attendees at House of Delegates meetings, including social events apart from House of Delegates meetings themselves. Hugs and embraces, while not always inappropriate, are not universally accepted. Meeting attendees are reminded of their personal responsibility, while greeting others, to consider how the recipient of their greeting is likely to interpret it. Instances of unwelcome or inappropriate behavior should be brought to the attention of the Speakers.

**SUPPLEMENTARY REPORT - Sunday, November 11****HOUSE ACTION: ADOPTED AS FOLLOWS****LATE RESOLUTIONS 1001-1003 ACCEPTED****EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 203, 214, 219, 221, 222, 223, 809, 813, 815, 816, 817, 819, 821 and 958**

Madam Speaker, Members of the House of Delegates:

**(1) LATE RESOLUTIONS**

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

Recommended for acceptance:

- Late 1001 - Affirming the Medical Spectrum of Gender (Resolution 5)
- Late 1002 - Inappropriate Use of CDC Guidelines for Prescribing Opioids (Resolution 235)
- Late 1003 - Oppose FDA’s Decision to Approve Primatene Mist HFA for Over the Counter Use (Resolution 927)

**(2) REAFFIRMATION RESOLUTIONS**

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

- Resolution 203 – Support for the Development and Distribution of HIPAA-Compliant Communication Technologies
- Resolution 214 – A Public Health Case for Firearm Regulation
- Resolution 219 – Promotion and Education of Breastfeeding
- Resolution 221 – Regulatory Relief from Burdensome CMS “HPI” EHR Requirements
- Resolution 222 – Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS
- Resolution 223 – Permanent Reauthorization of the State Children’s Health Insurance Program
- Resolution 809 – Medicaid Clinical Trials Coverage
- Resolution 813 – Direct Primary Care Health Savings Account Clarification
- Resolution 815 – Uncompensated Physician Labor
- Resolution 816 – Medicare Advantage Plan Inadequacies
- Resolution 817 – Increase Reimbursement for Psychiatric Services
- Resolution 819 – Medicare Reimbursement Formula for Oncologists Administering Drugs
- Resolution 821 – Direct Primary Care and Concierge Medicine Based Practices
- Resolution 958 – National Health Service Corps Eligibility

**APPENDIX – Reaffirmed policy and actions taken**

- 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 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 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 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 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 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 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 958 – National Health Service Corps Eligibility
  - Addressing the Shortage of Child and Adolescent Psychiatrists D-200.978

### **CLOSING REPORT – Tuesday, November 13**

#### **HOUSE ACTION: ADOPTED**

Madam Speaker, Members of the House of Delegates:

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Bailey, and the Vice Speaker, Doctor Scott, for the outstanding manner in which they have assisted our deliberations by their fair and impartial conduct of the House of Delegates and to commend the members of the House for their cooperation in expediting the business before us.

Your Committee wishes at this time to offer the following Resolution:

Whereas, The Interim Meeting of the House of Delegates of the American Medical Association has been convened in National Harbor, Maryland, during the period of November 10-13, 2018; and

Whereas, This Interim Meeting of the House of Delegates has been most profitable and enjoyable from the viewpoint of policy deliberations and fellowship; and

Whereas, The City of National Harbor has extended to the members attending this meeting the utmost hospitality and friendliness; therefore be it

RESOLVED, That expressions of deep appreciation be made to the AMA Board of Trustees for arranging this meeting, to the management of the Gaylord National Resort and Convention Center, to the City of National Harbor, and to the splendid men and women of our American Medical Association staff who participated in the planning and conduct of this Interim Meeting of the House of Delegates.

Madam Speaker, this concludes the Report of the Committee on Rules and Credentials, and we recommend its adoption

**APPROVAL OF MINUTES:** The Proceedings of the 167<sup>th</sup> Annual Meeting of the House of Delegates, held in Chicago, June 9–13, 2018, were approved.

**ADDRESS OF THE PRESIDENT:** AMA President Barbara L. McAneny, MD, delivered the following address to the House of Delegates on Saturday, Nov. 10.

Madam Speaker, officers, delegates, physician colleagues, distinguished guests, it is an honor to address you again as your president. First, let me thank our veterans, our military members currently on active duty, their spouses and family members who are here with us on Veterans Day weekend. We are very proud of you, and grateful for your service.

I want to tell you a story about a patient I saw recently in my Gallup practice. This man has metastatic prostate cancer to his bones, and he is doing well on his chemotherapy, so he will live for many years. But metastatic prostate cancer in your bones hurts, and one day he called me to say that his pain regimen wasn't holding him. So, I increased the dosage of his opioids from two per day to three and of course he ran out early.

In Gallup we cannot e-prescribe. Patients must carry a paper prescription to the pharmacy, and my patient lives an hour away from the Gallup clinic. So, I called his primary care physician who agreed to write a prescription for his very large amount of time-release morphine. The patient picked up the prescription and took it to his pharmacy. The pharmacist then called for the prior authorization but was denied by the health plan. Then, he checked the PDMP and learned that my patient had multiple prescriptions over the years, some written by me, and some written by my partners. After all, we practice team based care! The pharmacist suspected my patient was a drug seeker, and did not alert me that his prescription was denied.

My patient, a very proud man, felt shamed and didn't know what to do. So, he went home to be as tough as he felt he could be. That worked for about three days, and then he tried to kill himself. Fortunately, his family found him in time, and the emergency medicine physician was able to save his life. He spent a week in the hospital and finally we got his pain back under control, on the exact regimen I had prescribed him as an outpatient. The insurance company paid the ambulance and the hospital bill without any prior authorization. Like you, I share the nation's concern that more than 100 people a day die of an overdose. But my patient nearly died of an under-dose.

This story illustrates the problems we all confront every day in our current dysfunctional health care system. First, the health plan made a medical decision without knowing the patient. The health plan does not have the chart, doesn't know the patient, and basically countermanded my orders without even telling me, using the prior authorization process. How have we let health plans determine the course of care? They call this quality?

The health plan bears no liability for the patient's outcome, but they do carry the responsibility because prior authorization does not require that the "trained denial personnel" call the doctor and let them know that they changed the plan. The denials are immediate and even in cases where we know the drug is denied, it may take days to appeal it, and in the meantime patients suffer. Ninety percent of physicians surveyed by the AMA report that the prior authorization process has led to delays in care and decreased quality of care. This is unacceptable.

Fixing prior authorization is a huge priority for the AMA as we fight against the dysfunction in our system. We need to reduce the intensity of prior authorization, ensure that it is evidenced based and stream-lined through automation that doesn't create another physician work flow problem. The AMA is leading a coalition to standardize and streamline requirements in prior authorization to minimize care delays. We are fighting alongside our state and specialty medical societies to eliminate burdensome prior authorization and fail-first requirements. I invite you to join our FixPriorAuth campaign. Share your stories on FixPriorAuth.org. Or better yet, stop by the Grassroots Booth to share your story on video, as I will do tomorrow.

My patient suffered, in part, because of the crackdown on opioids. The pendulum swung too far when pain was designated a vital sign, and now we are in danger of it swinging back so far that patients are being harmed. We need to use our expertise in patient care to change the dialogue to appropriate pain control through a selection of possible therapies and to treat opioid use disorder as the relapsing chronic disease that it is. We must press policymakers to expand coverage and access to treatment programs. We applaud Pennsylvania in their recent victory to remove prior authorizations from Medication Assisted Therapy.

This is a great example of rational insurance design. We don't want to lose the teachable moment for patients motivated to treat their addiction. We have made progress in addressing the Opioid Epidemic through the work of our Opioid Task Force and those efforts will continue. Congress recently passed, and the president signed, bipartisan opioid legislation with many provisions supported by the AMA that will enhance treatment and prevention.

When I visited my patient in the hospital as he was recovering from his suicide attempt, I apologized for not knowing his medication was denied. I felt I had failed him. This is what leads to burnout, the frustration of knowing what the patient needs and having the health care system get in the way and prevent that care.

My experience is not unique. As I travel around the country and listen to doctors, I have come to realize that physician burnout is so often about frustration and feeling that we've lost control which makes it very difficult to go home at the end of the day and feel good about what we accomplished for our patients.

Too often the health care system gets in the way of actual health care. I hear from hospital-employed doctors as their contracts come up for renewal, wondering why they are being told to see more patients in less time and for less money.

At the same time, we see hospitals merging, health plans merging, and pharmacy benefit managers acquiring health plans. These systems get more profitable, while choices for patients and doctors diminish. Yoga at lunch isn't going to fix this one. I feel a sense of urgency as we are witness to greater concentration of wealth and power in the hands of ever-larger corporations, with more and more middlemen pulling down large salaries while our patients go broke and physician practices struggle to survive.

Concern about increased consolidation and what it means for patients is why the AMA opposed, and helped to defeat, the mergers of Anthem and Cigna, and Aetna and Humana, last year. This year, we fought a similar battle: the acquisition of Aetna by CVS Health Corporation. Again, we lobbied hard and urged the Department of Justice to block the merger. So, we were disappointed last month when they decided to let it proceed. However, we won a very important concession. The Justice Department is requiring divestiture of Aetna's Medicare Part D prescription drug business as a condition of the merger, a move that we hope will help protect competition in those important markets.

And we will be watching drug pricing in this merged system, because another issue that is interfering with patient care is the skyrocketing cost of prescription drugs. We get frustrated when our patients cannot afford the medicine they need. No one should have to suffer because they cannot afford pain medicine, just as we cannot let high drug prices prevent someone from managing their chronic disease. The AMA is fighting for drug price and cost transparency at both the state and federal levels. We are also activating our grassroots network through TruthinRx.org, a website for physicians and patients to tell their stories and lobby Congress directly.

We all know that health care costs in this country are unsustainable. We spend three and a half trillion dollars yearly now, and if nothing changes we will spend \$5.7 trillion in 2026. That means no money for schools or fire departments or bridges that don't fall down. We know that cannot happen. It has to change, and it will. But who will lead that change? Hospital systems? Health plans? PhRMA? PBMs? Or doctors?

Are doctors positioned to make a difference? We are! Health care runs on our licenses, so we have the power to fix it. When doctors work together, for the good of patients, we are unstoppable. The AMA is our voice to create a health care system that provides health for patients, not profits for middlemen. How will we do that? The best way to keep health care bills down is to intervene early in the chronic diseases that account for 90 cents of every dollar we spend on health care.

Our Improving Health Outcomes program is reaching more prediabetics and giving doctors the tools to help patients to control their disease, stay healthy and avoid the expensive complications that are breaking the bank. But we know when diabetics live in food deserts, when there are limited options for fresh food and few safe places to exercise, their outcomes will suffer. If we are going to keep our patients with chronic diseases healthy and working instead of making them permanent customers of the health care system, we must reach all people. We must be able to intervene to address and improve the social determinants of health.

That includes childhood traumas, which is why we protested the separation of children from their mothers at the border, why we continue to advocate for mental health parity, and why we must take women seriously when they tell us they are sexually harassed. And that includes those being harassed in our own profession! I was disappointed to read the recent study indicating large numbers of our female colleagues are still being harassed. We cannot point fingers at others if our own house is not in order. It must stop now. Time's up! The AMA stands for equality—whether you are my patient or my colleague! Our Code of Ethics commits us to treat all patients—and one another—ethically and professionally. We've got this. We can do it.

In the United States, we know that health care costs rise when behavioral health is neglected and that access to care is about having insurance that actually covers the cost of your care. We all know that people without insurance live sicker and die younger than those who have it. That is why we have fought efforts in Washington DC and at the state level to strip away patient protections gained through the Affordable Care Act. We don't want to see children tossed

off their parent's plans. I am a cancer doctor. All of my patients have pre-existing conditions that would make them uninsurable forever, and I don't want to go back to those bad old days.

We don't want insurance companies spending large sums of our patients' premiums on wasteful administrative overhead. We know as doctors that paperwork wastes money and we are pleased that the Administration and HHS is taking action to put patients before paperwork.

We did have some concerns about the recent proposal on E and M codes to pay physicians the same for a visit for a modest problem as for highly complex care. We worked with CMS in a collaborative way and achieved a two-year breathing space for an AMA-led workgroup to develop potential E and M coding changes to support the level of care we all want for patients. We will continue, as we always have, to work with all branches of government to make it easier for doctors to take care of patients. We will work with the private payers for rational health policy.

We are working to end EHR abuse as well. Doctors are spending excessive time on data entry, contributing to physician burnout, with implications for quality of care. Much of the EHR technology is dysfunctional; it grew out of the billing software, so it doesn't give us the decision support or the information we need. The vendors of these systems like to paint doctors as Luddites who don't like technology. They need to understand that we love technology; we just want technology that works.

The AMA has convened health plan vendors and doctors to address the problems, and we are working on interoperability. Health plans and hospitals use data blocking or inconvenience to keep patients trapped in their systems. Doctors just want the results of the tests. Hey Siri, what was the result of Mr. Smith's CT done in the ED last night?

We will not let dysfunction infect the "internet of things" that will be a part of the health care system of the future. Dr. Madara will tell you about our efforts there, and he deserves credit for having the vision to move the AMA forward in that space. We will continue to help physicians figure out better ways to structure their practices, and then adapt the payment system so that they can deliver the care that they know patients need, and be fairly paid for it! This is how we will lower the price tag on health care. Physicians know what would work in their specialty and their community, and the AMA is trying to give them the support and opportunity to make those changes. So, the AMA steps in where others fear to tread, and it will take time but we will get there.

Gun violence is another area where many "fear to tread." Just in the last two weeks we have mourned still more senseless deaths from the mass shootings in Pittsburgh, and in Thousand Oaks. Meanwhile, the CDC reported yesterday that both firearm homicides and suicides are at their highest levels in more than a decade. Friends, these deaths—from mass shootings, from suicide, from children gaining access to a parent's firearm—are preventable. Thoughts and prayers just won't cut it anymore. Policymakers at the state and federal level must act on common-sense, data-driven measures to prevent yet more carnage.

We must also continue to speak out. We are the AMA. Sooner or later, we are all patients, and patients need doctors. It is our job, our calling and our mission to create a health care system that recognizes and supports the efforts of dedicated medical professionals. We need to create a system that values health over money, power and politics.

We can do this, and we must do this. We are the AMA!

Thank you.

**REPORT OF THE EXECUTIVE VICE PRESIDENT:** James L. Madara, MD, executive vice president of the Association, delivered the following address to the House of Delegates on Saturday, Nov. 10.

Madam Speaker, Madam President, members of the Board, delegates, and guests. There's a tension in health care today that simply reflects our current surrounding chaos. Patients feel it. We feel it. We're not sure what changes lie ahead; there's little consensus about which path will be taken. It brings to mind a line from the 19<sup>th</sup> century novel, *Middlemarch*, "With dim lights and tangled circumstance, they tried to shape their thought." In times of uncertainty, people look to public trusts like the AMA to chart a course through such dim light and tangled circumstance. So, how



can we deliver this? We can do so by striking the right balance between the urgent needs of physicians today while taking steps to address the needs of tomorrow.

You just heard Dr. McAneny highlight several of the ways the AMA is leading efforts around the immediate critical needs to improve the environment for patient and physicians. But the truth is, we also have vast structural gaps, which will undoubtedly require long-term work. And if these large projects don't start with physicians, we'll find ourselves in a future where, once again, optimally supportive infrastructure is lacking. The need to fill these gaps is fundamental, and will remain so, regardless of what health care system exists 10 or even 20 years from now.

Gaps in how we deal with our increasing chronic disease burden, gaps in how clinical data is organized at the point of care, gaps in achieving true data liquidity and interoperability and gaps in availability of delightful tools that make more effective use of physician time. For physicians, those two words—delightful and tools—may never have been spoken before in the same sentence!

The AMA's work is organized as three strategic arcs -- which I described last June:

- First: Reimagining medical education, training, and lifelong learning;
- Second: Improving the health of the nation by confronting the rise in chronic disease; and
- Third: Attacking the dysfunction in health care.

As you will recall, the original arcs were created from what I call the meta-signals of our policy portfolio. "Meta" since each represents a tapestry created by numerous inter-related policy threads. Within each of these arcs there's work for the moment but also work toward filling those gaps, those vast infrastructural needs. Let me give some examples of where we are in all of this:

This fall we announced the next phase of our reinvention of medical education. First, we renewed our commitment to all 32 schools in our Accelerating Change in Medical Education—or ACE—consortium, fueling even more innovative approaches to medical education over the next three years. In parallel, we launched a logical extension of this work: transforming residency training in the same way we've transformed medical schools. This effort will allow a more fluid transition from medical school to residency and better prepare the next generation of physicians.

In the strategic arc focused on chronic disease, the AMA's efforts to slow or reverse the increasing prevalence of high blood pressure and diabetes is radically expanding. More than 1,600 health systems and physician practices nationwide have now joined our efforts on Target BP, a joint project with the American Heart Association that has a shared goal of better blood pressure control to reduce the number of Americans with heart attacks and strokes each year. More than 8 million people are now in this program, which we launched less than three years ago. Last month we recognized more than 300 physician practices for achieving a control rate above 70 percent. Studies show that every 10-point reduction in blood pressure lowers the risk for heart failure and stroke by one-quarter.

To stem the rise in diabetes, we are launching a new public service campaign next week in coordination with National Diabetes Awareness Day. And more than one million people have so far self-screened for prediabetes thanks to our previous national campaign, created in collaboration with the CDC and the Ad Council. In addition, the innovation company we founded in Silicon Valley, Health2047, has, just in the last few weeks, spun off a new company that aspires to provide community-based, peer-to-peer coaching to help people with prediabetes make the lifestyle choices that can keep their condition from advancing. This new company, called First Mile Care, is intended to fill the gap in our current health care model, a model that, by experience, seems wholly ineffective at addressing lifestyle issues related to chronic disease.

Using an Uberized approach – the right time, the right place and the right match, First Mile Care will build a network of 100,000 digitally certified lifestyle coaches across all 42,000 US zip codes. These are coaches in local communities, who will deploy programs that are shown to reduce by half a patient's chances of developing type 2 diabetes. Diabetes prevention programs have existed for nearly a decade, yet less than half of one percent of people with prediabetes in the U.S. have completed such a program, and so an approach that is scalable and easier to access is desperately needed.

First Mile Care is the second spinoff from Health2047, joining Akiri, which I highlighted last June. Akiri is building an inexpensive, secure, clinical data liquidity platform, another one of those infrastructural gaps that needs to be filled. Now, key to the success of these companies is that both began by carefully defining the common frustrations

physicians face, and are devising solutions with the expertise and experience of physicians. You can learn more about each of these exciting new projects at [Health2047.com](http://Health2047.com) and [Akiri.com](http://Akiri.com).

Another example of our work toward the future was unveiled at the Connected Health Conference in Boston last month: a new Digital Health Implementation Playbook, which provides a clear and efficient route to choosing and adopting digital health solutions in clinical practice. This Digital Health Playbook helps map out key steps, best practices and other resources to accelerate digital health adoption, such as remote patient monitoring. The Playbook was celebrated in the biomedical technology literature over the last month and, in the first week, over twelve hundred physicians downloaded this tool.

Physicians are optimistic about the potential of digital innovations to benefit patients and improve health care, but adoption can be challenging. That's why new solutions must facilitate, not complicate medical practice. These solutions must save time, not take time.

As we all know, the rapid pace of change today is overwhelming many physician practices and can disrupt the delivery of care. We gained insights into just how disruptive in a follow-up AMA-RAND study on physician payment models released last month. This study captured with rigor the complexity of today's clinical environment and how an over-emphasis on data entry, paperwork, insurance hassles and a multitude of payment models weighs heavily on physicians. We want to deliver the very best care to patients but we're wary of exposure to downside financial risk. So, what things specifically need we improve?

Strong hints come from that same study. Physicians highlight the fact that they don't receive the well-organized and timely clinical data they need to make meaningful practice improvements. The lack of timely, trusted and better organized data, as well as a lack of data liquidity, all conspire to diminish the visibility of our practices. It's like driving a car with a windshield covered in snow. No wonder physicians are wary of downside risk!

This is why we are working on a data liquidity system such as Akiri, and why we launched the Integrated Health Model Initiative or IHMI, which I introduced to you at Interim one year ago. IHMI is another example of how we're filling the gaps that exist in health care today, drawing upon the expertise and needs of physicians to build a data model that delivers more accurate, actionable, clinically-validated, and organized data to better serve patients. IHMI has already developed a prototype demonstrating how remote blood pressures, taken in the right context, can be captured and organized within a distant medical record, without archaic paper, faxes, or note keeping. This coming year, as part of the model to address hypertension, IHMI will also capture often overlooked elements, such as patient goals and social determinants of health.

These are pioneering efforts that engage stakeholders across the health care industry and carry the promise of fundamentally improving how clinical data is organized, coherently presented, and appropriately shared. Initiatives such as these, if truly foundational, should be able to attract sophisticated and experienced leaders. And they have.

The founder and CEO of First Mile Care is Karl Ronn, a globally successful entrepreneur and advisor to Fortune 500 companies. He also led R & D at the consumer powerhouse Procter & Gamble, where he directed new business in the health care domain.

Akiri attracted, as CEO, the health information technology pioneer, Dave Watson, a founder of the California Integrated Data Exchange, a former Chief Technology Officer for Kaiser Permanente, and the global head for health care strategy at Oracle.

We also successfully lured Dr. Tom Giannulli to lead the next phase of IHMI. Tom is both a physician and bioengineer and launched leading-edge digital companies, such as the first EHR for the iPhone, a company that was later acquired by Epocrates. These are experienced, talented and creative people who share our goal of charting the future of medicine.

These are not trivial projects, and they will take some years to develop and implement. But imagine if we had deployed these same patient- and physician-focused approaches years ago when our current electronic platforms were being built. Our health care system would be in a far better place today.

Disruptive thinking has always preceded major advancements in science and technology. Consider this story: in the middle ages, leading astronomers believed in a geocentric model that had the earth at the center of the solar system being orbited by the sun and the other planets. This confounded mathematicians because it was difficult to produce the math to describe this model. It was Copernicus who identified the correct model with the sun at the center and the challenges of supporting it immediately fell away because he had correctly defined it.

That story illustrates where we are in health care today. In working toward solutions, we always have to start at the right place, the place where the larger truth about health care exists. This is not found at the administrative level, orbited by patients and physicians, but at the patient-physician relationship. This relationship is the sun in our health care solar system, the place where problems must be identified and where we must focus our solutions.

At the AMA, we will always be guided by two simple questions: What is best for our patients? And how do we improve the clinical environment so that physicians have more time and better tools to serve their needs? Addressing these fundamental questions is how we continue to deliver on the AMA's mission: "to promote the art and science of medicine and the betterment of public health."

Thank you.

**REMARKS FROM THE CHAIR OF THE AMPAC BOARD:** The following remarks were presented to the House of Delegates on Saturday, November 10, by Vidya Kora, MD, Chair of the AMPAC board.

Thank you, Madam Speaker. Good afternoon, fellow delegates. I am Vidya Kora from Michigan City, Indiana. It is my pleasure to be here today as the Chair of AMPAC, the bipartisan political action committee of our AMA.

First, I would like to thank those of you who invested in AMPAC this year. Today, HOD participation stands at 80%, the highest percentage in HOD history. While this is good news, I remain hopeful that one day we will have 100% participation with every member participating at the Capitol Club Silver level or higher. Your investment helps ensure that organized medicine's voice remains steadfast and forceful in an ever-changing political environment.

It has certainly been a busy and tumultuous election cycle for medicine. As Tuesday's election proved once again, campaigns are becoming longer, more expensive and challenging to navigate with an unsettled political environment. Health care was at the forefront of the national political debate and battle lines were drawn early on.

This election cycle, AMPAC carefully threaded the needle to find candidates who were not on the extreme end of their respective party's spectrum. Our advocacy efforts focused on solution-oriented politicians committed to making progress on very complicated health care issues. AMPAC's strategy continues to be focused on building long-term relationships with leaders in Congress, who are true champions of medicine.

In 2018, AMPAC contributed over \$1.4 million in direct contributions to 291 physician-friendly candidates for the U.S. House and Senate from both political parties. These contributions provided advocates for medicine more than 600 strategic opportunities to attend events and have important one-to-one interactions with candidates and discuss issues critical to medicine.

A total of 250 AMPAC supported candidates won their election or reelection and this includes medicine's top allies currently in Congress as well as several incoming freshmen. Your advocacy team in Washington is eager to begin building relationships with these newly elected members and educating them on the issues that matter most to physicians.

Now that the elections are over, it is time for all of us to reconcile the new political agendas in Washington. I feel this uncertainty is more about new opportunity. It is in times like these that we need steady leadership. AMPAC is poised to provide this steady leadership, but not without your help.

Now before you start throwing tomatoes at me, fundraising for the 2020 cycle has begun, YES, there is no rest for the weary! Please commit now to joining AMPAC for 2019 at AMPAC's booth that's right outside of this room and take care of this very important duty to your profession. Thank you!

**REPORT OF AMPAC'S BOARD OF DIRECTORS:** The following report was submitted by Vidya Kora, MD, Chair of AMPAC.

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 funds 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 L<sup>TM</sup>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](http://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.

**RETIRING DELEGATES AND MEDICAL EXECUTIVES**

**Delaware**

Kelly S. Eschbach, MD

**Kansas**

Terry Poling, MD

**Massachusetts**

Francis MacMillan, Jr, MD

**Nebraska**

Dale Mahlman

**New York**

Paul A. Hamlin, MD

**North Carolina**

John R. Mangum, MD

**Ohio**

Charles Hickey, MD

**Vermont**

Robert Block, MD

**West Virginia**

Constantino Y. Amores, MD

**American College of Emergency Physicians**

Jennifer Wiler, MD

## REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES (I-18)

### Reference Committee on Amendments to Constitution and Bylaws

Todd M. Hertzberg, American College of Radiology, Chair  
 Mark Ard, MD, California  
 Jayne E. Courts, MD, Michigan\*  
 Keith E. Davis, MD, Idaho\*  
 Sean Figy, MD, American Society of Plastic Surgeons, Sectional Resident  
 Dionne Hart, MD, Minority Affairs Section  
 Spiro Spanakis, MD, Massachusetts\*

### Reference Committee B (Legislation)

Francis P. MacMillan, Jr., MD, Massachusetts, Chair  
 Sue Bornstein, MD, American College of Physicians  
 Tilden L. Childs, III, MD, American College of Radiology  
 Daniel P. Edney, Mississippi\*  
 Ross F. Goldberg, MD, Arizona\*  
 Raymond Lorenzoni, MD, New York, Sectional Resident  
 Bruce A. MacLeod, MD, Pennsylvania\*

### Reference Committee C (Medical education)

Peter C. Amadio, MD, American Association for Hand Surgery, Chair  
 Jerry P. Abraham, MD, MPH, American Academy of Family Physicians  
 John C. Moorhead, MD, American College of Emergency Physicians  
 Lucy Nam, Maryland\*  
 Brigitta J. Robinson, MD, Colorado\*  
 Martin D. Trichtinger, MD, Pennsylvania  
 Roxanne Tyroch, MD, Texas\*

### Reference Committee F (AMA finance, governance)

Greg Tarasidis, MD, South Carolina, Chair  
 Michael D. Chafty, MD, Michigan  
 Melissa J. Garretson, MD, American Academy of Pediatrics  
 Jerry L. Halverson, MD, American Psychiatric Association  
 Candace E. Keller, MD, American Society of Anesthesiologists  
 A. Lee Morgan, MD, Colorado  
 Ann R. Stroink, MD, Congress of Neurological Surgeons

### Reference Committee J (Medical practice)

Steven Chen, MD, American Society of Breast Surgeons, Chair  
 Timothy M. Beittel, MD, North Carolina\*  
 Nitin S. Damle, MD, American College of Physicians  
 Florence Jameson, MD, Nevada  
 Steve Lee, MD, American Society of Clinical Oncology\*  
 Adam Panzer, Colorado, Regional Medical Student  
 Susan M. Strate, MD, College of American Pathologists\*

### Reference Committee K (Science and technology)

Darlyne Menscer, MD, North Carolina, Chair  
 Robert L. Allison, MD, South Dakota\*  
 Daniel B. Kimball, Jr., MD, Pennsylvania  
 Sarah Marsicek, MD, American Academy of Pediatrics, Sectional Resident\*  
 Daniel M. Meyer, MD, American Association for Thoracic Surgery  
 Reid Orth, MD, American College of Emergency Physicians  
 William S. Pease, MD, American Association of Neuromuscular & Electrodiagnostic Medicine

### Committee on Rules and Credentials

David T. Walsworth, MD, Michigan, Chair  
 Barbara J. Arnold, MD, California\*  
 Rebecca Brendel, MD, American Psychiatric Association\*  
 Ralph J. Nobo, Jr., MD, Florida  
 Kevin C. Reilly, MD, Radiological Society of North America\*  
 Colette R. Willins, MD, American Academy of Family Physicians

### Chief Teller

Billie L. Jackson, MD, Georgia

### Assistant Tellers

Donna Bloodworth, MD, American Academy of Pain Medicine\*  
 Paul D. Bozyk, MD, Michigan\*  
 William C. Davison, MD, American Academy of Neurology\*  
 Ronald L. Harter, MD, American Society of Anesthesiology\*  
 Woody Jenkins, MD, Georgia\*  
 Ali Rahimi, MD, Georgia\*  
 Steven P. Shikiar, MD, New Jersey\*

\* Alternate delegate