2020 AMA Organized Medical Staff Section Interim Meeting
Manchester Grand Hyatt and Marriott Marquis, San Diego
November 14-16, 2019

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For the best user experience, please download a copy of this handbook to your personal device
This is what we expect of our members and guests at AMA-sponsored events.

All attendees are expected to exhibit respectful, professional and collegial behavior consistent with the Code of Conduct passed by the AMA House of Delegates.

We take claims of harassment and conflicts of interest seriously. Visit ama-assn.org/codeofconduct to learn more. Violations of the Code of Conduct may be reported as follows:

- Conduct liaison assigned to the meeting
- AMA Office of General Counsel
- AMA speaker or vice speaker
- Our third-party hotline at (800) 398-1496 or online at lighthouse-services.com/ama (which includes an anonymous reporting option)
# 2019 AMA Organized Medical Staff Section Interim Meeting

**Marriott Marquis and Manchester Grand Hyatt**  
**San Diego, California**  
**November 14-16, 2019**

Meeting times and locations are subject to change. Download the AMA meetings app to stay up to date, build your own schedule, and more!

## Wednesday, November 13

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<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>4:00 p.m.</td>
<td>Deadline to submit late resolutions (email to <a href="mailto:rick.abrams@ama-assn.org">rick.abrams@ama-assn.org</a>)</td>
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## Thursday, November 14

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<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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| 11:30 a.m.-3:00 p.m.      | OMSS credentialing  
*Please register and pick up your meeting badge in the Palm Foyer, Second Level, Manchester Grand Hyatt before credentialing as an OMSS representative at the Marriott Marquis.* | Marina G Foyer – Marriott Marquis (MM) |
| 11:15 a.m.-12:00 noon     | Committee on Late Resolutions meeting                                  | Temecula 1 - MM           |
| 12:00 noon-1:30 p.m.      | Caucus meetings  
- Cowchip caucus  
- Great Atlantic Seaboard caucus  
- Heartland caucus  
- Western caucus       | Vista - MM  
Santa Rosa – MM/  
Marina G - MM  
Temecula 2 - MM |
| 1:30-2:00 p.m.            | “You thought you only had a duty of care to your patients?” – Minnesota’s Warren v. Dinter decision. Speaker: Leonard Nelson, Esq., Senior Assistant General Counsel, American Medical Association | Marina G - MM |
| 2:00-5:00 p.m.            | Business meeting and Reference Committee hearing                       | Marina G - MM |
| 6:00-7:00 p.m.            | Reception                                                              | Poolside - MM |


### Friday, November 15

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<tr>
<th>Time</th>
<th>Event</th>
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| 7:30-10:15 a.m. | OMSS credentialing  
*Please register and pick up your meeting badge in the Palm Foyer, Second Level, Manchester Grand Hyatt before credentialing as an OMSS representative at the Marriott Marquis.* | Marina G Foyer - MM |
| 7:30-9:00 a.m. | Caucus meetings  
- Cowchip caucus  
- Great Atlantic Seaboard caucus  
- Heartland caucus  
- Western caucus |  
- Vista - MM  
- Catalina - MM  
- Marina G - MM  
- Oceanside - MM |
| 10:00 a.m. | Deadline to submit amendments (see staff in Marina G Foyer) |  |
| 10:15 a.m.-12:15 p.m. | Business meeting | Marina G - MM |
| 12:30-1:15 p.m. | Lunch and open forum: AMA Policymaking Life Cycle – Turning ideas into policy and then into solutions! Speaker: Matthew Gold, MD, Chair, OMSS Policy Committee | Marina G - MM |
| 1:30-2:30 p.m. | The Credentialing, Privileging and Enrollment Processes: What you don’t know can hurt you! Speakers: Tammy Weaver, Director, Database Products Portfolio, American Medical Association; Susan Diaz, CPCS, CPMSM, President, National Association Medical Staffing Services (NAMSS) | Marina G - MM |
| 2:45-3:45 p.m. | Demystifying Employment Contracts – Speaker: Richard Levenstein, Esq. Nason, Yeager, Gerson, Harris & Fumero | Marina G - MM |
| 4-5 p.m. | State Chairs meeting | Santa Rosa - MM |

### Saturday, November 16

**Education sessions are open to all meeting attendees**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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| 8:00-8:45 a.m. | US health care reform – Diving into economic, physician, and patient aspects of proposed health care  
*Hosted by the AMA Medical Student Section* | La Costa - MM |
| 8:30-9:15 a.m. | Developing sustainable global health projects in the age of voluntourism  
*Hosted by the AMA Medical Student Section* | Coronado - MM |
| 8:30-9:15 a.m. | Amplify your voice: How physicians can shape health policy  
*Hosted by all AMA Sections and Advisory Committees* | Harbor Ballroom G-H Manchester Grand Hyatt (MGH) |
| 9:00-9:45 a.m. | Identifying clinical problems and driving needs-oriented innovation in medicine  
*Hosted by the Medical Student Section* | La Costa-MM |
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<tr>
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<tbody>
<tr>
<td>9:30-10:15 a.m.</td>
<td>Using cost effectiveness to determine coverage priorities Hosted by the AMA Medical Student Section</td>
<td>Coronado-MM</td>
</tr>
<tr>
<td>9:30-10:30 a.m.</td>
<td>Demystifying Employment Contracts – Speaker: Richard Levenstein, Esq., Nason, Yeager, Gerson, Harris &amp; Fumero</td>
<td>Harbor Ballroom G-H-MGH</td>
</tr>
<tr>
<td>9:45-11:00 a.m.</td>
<td>The new MOC: Update on ABMS Continuing Board Education Co-Hosted by AMA Academic Physicians Section, the AMA Young Physicians Section and the AMA Council on Medical Education</td>
<td>Grand Hall D-MGH</td>
</tr>
<tr>
<td>10:00-10:45 a.m.</td>
<td>Telemedicine and mobile apps – accessing birth control without stepping foot in a clinic Hosted by the AMA Medical Student Section</td>
<td>La Costa-MM</td>
</tr>
<tr>
<td>12:00 noon-1:30pm</td>
<td>The impact of vision and hearing loss in the senior population – Why seeing and hearing are believing Hosted by the AMA Senior Physicians Section</td>
<td>Grand Hall C-MGH</td>
</tr>
<tr>
<td>2-6 p.m.</td>
<td>House of Delegates meeting – Opening session Hosted by the AMA Medical Student Section</td>
<td>Seaport Ballroom – MGH</td>
</tr>
<tr>
<td>5:15-6:00 p.m.</td>
<td>Fair market pricing for prescription drugs Hosted by the AMA International Medical Graduates Section</td>
<td>Harbor Ballroom B – MGH</td>
</tr>
<tr>
<td>6:00-6:30 p.m.</td>
<td>Investigating gender bias in medical student evaluations Hosted by AMA Women Physicians Section</td>
<td>Harbor Ballroom A MGH</td>
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**Sunday, November 17**

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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>6:30-7:30 a.m.</td>
<td>OMSS caucus All AMA members with an interest in organized medical staff issues are invited to attend. Invite your colleagues!</td>
<td>Delmar-MM</td>
</tr>
<tr>
<td>8-8:30 a.m.</td>
<td>House of Delegates meeting – Second opening session</td>
<td>Seaport Ballroom-MGH</td>
</tr>
<tr>
<td>8:30 a.m.-12 p.m.</td>
<td>House of Delegates Reference Committee hearings Hosted by the AMA Medical Student Section</td>
<td>Grand Hall C-MGH</td>
</tr>
<tr>
<td></td>
<td>Reference Committee on Amendments to Constitution &amp; Bylaws</td>
<td>Harbor Ballroom G-I-MGH</td>
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<td></td>
<td>Reference Committee B (Legislation)</td>
<td>Harbor Ballroom A-C-MGH</td>
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<td>Reference Committee C (Medical Education)</td>
<td>Harbor Ballroom A-C-MGH</td>
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<td></td>
<td>Reference Committee F (AMA Governance and Finance)</td>
<td>Seaport Ballroom-MGH</td>
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<tr>
<td></td>
<td>Reference Committee J (Medical Service, Medical Practice, Insurance)</td>
<td>Harbor Ballroom D-F-MGH</td>
</tr>
<tr>
<td></td>
<td>Reference Committee K (Science and Public Health)</td>
<td>Grand Hall D - MGH</td>
</tr>
<tr>
<td>1-2:00 p.m.</td>
<td>OMSS caucus</td>
<td>Pier - MGH</td>
</tr>
</tbody>
</table>
**All AMA members with an interest in organized medical staff issues are invited to attend. Invite your colleagues!**

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<tbody>
<tr>
<td>2-4:00 p.m.</td>
<td>Litigation Center Open Meeting</td>
<td>Harbor Ballroom D-F-MGH</td>
</tr>
</tbody>
</table>
# Meeting Logistics

| Wi-Fi: 2019INTERIM  
| Password: 2019INTERIM |
| Manchester Grand Hyatt hotel map  
| Marriott Marquis hotel map |
| Meeting app information |
Manchester Grand Hyatt

For the best user experience, please download a copy of this handbook to your personal device
Marriott Marquis  
Level One

For the best user experience, please download a copy of this handbook to your personal device.
For the best user experience, please download a copy of this handbook to your personal device
Marriott Marquis
South Tower - Level 3

For the best user experience, please download a copy of this handbook to your personal device
For the best user experience, please download a copy of this handbook to your personal device
Downloading the App

Get the app

1. Go to the right store. Access the App Store on iOS devices and the Play Store on Android.

*If you’re using a Blackberry or Windows phone, skip these steps. You’ll need to use the web version of the app found here:*
https://event.crowdcompass.com/amainterim19

[Scan here for online version]

2. Install the app. Search for CrowdCompass AttendeeHub. Once you’ve found the app, tap either Download or Install.

After installing, a new icon will appear on the home screen.

Find your event

1. Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter AMA 2019 Interim Meeting
2. Open your event. Tap the name of your event to open it.
The “CrowdCompassAttendeeHub” Mobile App - FAQ

Where can I download the mobile app?

Go to the correct store for your device type. Access the App Store on iOS devices and the Play Store on Android.

Install the app. Search for CrowdCompassAttendeeHub. Once you have found the app, tap either Download or Install. After installing, a new icon will appear on your home screen.

If you’re using a Blackberry or Windows phone, skip these steps. You’ll need to use the web version of the app found here https://event.crowdcompass.com/amaannual2019

How do I find the Event?

Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter: AMA 2019 Annual Meeting

The app is asking me to log in. Why do I need to log-in?

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop. Below is a list of some other great things you can do after logging in:

- Take notes
- Share photos
- Rate sessions
- Join the attendee list
- Check-in
- Share contacts
- Share over social media
- Take Surveys
- Message fellow attendees
Where can I get my log-in information?

The log-in process is largely self-managed. Just follow the steps below to log in from your device:

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next. Enter an email address, and then tap next again.

3. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

I’ve requested log-in information, but I never received an email.

If you haven't received your log-in information, one likely culprit may be your spam filter. We try to tailor our email communications to avoid this filter, but some emails end up there anyway. Please first check the spam folder of your email. The sender may be listed as CrowdCompass.

I lost my log-in info, and I forgot my confirmation code. How do I log myself back in?

To have a verification email resent to you, start by accessing the sign-in page.

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next.

3. **Click on Forgot Code:** If you've already logged in before, the app will already know your email address and will send a verification email to you again.

4. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You’ll see your confirmation code has already been carried over. Just tap Finish. You’ll be taken back to the Event Guide with all those features unlocked.

How do I create my own schedule?

1. **Open the Schedule.** After logging in, tap the Schedule icon.

2. **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.

3. **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.
How can I export my schedule to my device’s calendar?

1. **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.

2. Here you’ll see a personalized calendar of the sessions you’ll be attending. You can tap a session to see more details.

3. **Export it.** Tap the download icon at the top right of the screen. A confirmation screen will appear. Tap Export and your schedule will be added directly to your device’s calendar.

How do I allow notifications on my device?

Allowing Notifications on iOS:

1. **Access the Notifications menu.** From the home screen, tap Settings, then Notifications.

2. **Turn on Notifications for the app.** Find your event’s app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:

Note: Not all Android phones are the same. The directions below walk you through the most common OS, Android 5.0.

1. **Access the Notification menu.** Swipe down on the home screen, then click the gear in the top right. Tap Sounds and notifications.

2. **Turn on Notifications for your event’s App.** Scroll down and tap App notifications. Find your event’s app on the list. Switch notifications from off to on.

How do I manage my privacy within the app?

Set Your Profile to Private...

1. **Access your profile settings.** If you’d rather have control over who can see your profile, you can set it to private.

2. After logging in, tap the hamburger icon in the top left, and then tap your name at the top of the screen.

3. **Check the box.** At the top of your Profile Settings, make sure that the box next to “Set Profile to Private” is checked.

...Or Hide Your Profile Entirely
1. **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.

2. **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.

3. **Make sure the slider next to “Show Me On Attendee List” is switched off.** Fellow attendees will no longer be able to find you on the list at all.

**How do I message other attendees within the app?**

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.

3. **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then *My Messages.*

**How do I block a person from chatting with me?**

1. **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.

2. **Block the person.** Find the person you’d like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don’t type anything, instead tap Block in the top right.

**I want to network with other attendees. How do I share my contact info with them?**

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.

3. Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

**I want to schedule an appointment with other attendees. How do I do that?**

1. **Navigate to My Schedule.** Tap the hamburger icon in the top left, then *My Schedule.*

2. **Create Your Appointment.** In the top right corner of the *My Schedule* page you’ll see a plus sign. Tap on it to access the Add Activity page.

3. **Give your appointment a name, a start and end time, and some invitees.** When you’re finished, tap done. Invitations will be immediately sent to all relevant attendees.
How do I take notes within the app?

Write Your Thoughts...

1. **Find your Event Item.** After logging in, find the session, speaker, or attendee you’d like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you’ve found the item you’re looking for, tap on it.

2. **Write your note.** Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap done when you’ve finished.

...Then Export Them

1. **Navigate to My Notes.** Tap the hamburger icon in the top right, then My Notes. Here you’ll find all the notes you’ve taken organized by session.

2. **Choose where to send your notes.** Tap the share icon in the top right and CrowdCompass will automatically generate a draft of an email that contains all your notes. All you have to do is enter an email address, and then tap Send.
## Policy Materials

### Section resolutions

- **Resolution 1 – Where was the AMA?**
- **Resolution 2 – Medical Center Unconditional Auto Accept Policies**
- **Resolution 3 – Hospital Website Voluntary Physician Inclusion**
- **Resolution 4 – Drug Shortage Rapid Response Team**

### Section reports

- **GC Report A – HOD Handbook Review**
- **GC Report AA – OMSS Position on CEJA Report 02, Amendment to E-1.2.2, “Disruptive Behavior by Patients”**
- **GC Report BB – OMSS Position on CSAPH Report 03, Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals**

### Additional items of interest

*For the best user experience, please download a copy of this handbook to your personal device.*
Whereas, There have been several resolutions brought forth addressing serious concerns about e-cigarettes in recent years at the various levels within the sections of the AMA; and
Whereas, Many of these have come from the OMSS section, with calls for the AMA to put on a public face regarding this public health issue and show some leadership; and
Whereas, There has been little to no action by the organization which is always seeking more membership, greater public presence, and a more prominent standing as a premier advocate for the public health; and
Whereas, Time and years have passed since the introduction of these addiction devices with ever more deleterious fallout; therefore be it
RESOLVED, that a member of the executive body and/or Board of Trustees, who is familiar with this issue over these years, come before the OMSS with an explanation, background, and history of what has transpired at the public relations, policy and actions departments of our organization to justify this lack of a public stance on this important issue. (Directive to Take Action)

Fiscal Note: Not yet determined
Received: 10/02/2019

RELEVANT AMA POLICY:

Electronic Cigarettes, Vaping, and Health H-495.972

Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about “vaping” or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.
Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.

Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.

Citation: CSAPH Rep. 2, I-14; Modified in lieu of Res; 4156, A-15; Modified in lieu of Res. 419, A-15; Reaffirmed Res. 421, A-15; Modified CSAPH Rep. 05, A-18; Reaffirmed CSAPH Rep. 03, A-19; Appended Res. 428, A-19

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

Citation: Res. 206, I-13; Modified in lieu of Res. 511, A-14; Modified in lieu of Res. 518, A-14; Modified in lieu of Res. 519, A-14; Modified in lieu of Res. 521, A-14; Modified CSAPH Rep. 2, 1-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 412, A-15; Reaffirmed in lieu of Res. 419,
Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

Our AMA:
(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
(2) 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;
(3) 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;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) 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;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) 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;
(8) (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; and
(9) opposes the sale of tobacco at any facility where health services are provided; and
(10) supports that the sale of tobacco products be restricted to tobacco specialty stores.
Legal Action to Compel FDA to Regulate E-Cigarettes D-495.992

Our AMA will consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.

Citation: Res. 432, A-18

Taxation of All Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) H-495.987

Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to increase federal, state, and local excise taxes on all tobacco products and electronic nicotine delivery systems (ENDS), including e-cigarettes, in order to discourage use.

An increase in federal, state, and local excise taxes for such products should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts.

Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of all tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating such advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education.

Citation: CSA Rep. 3, A-04; Modified: BOT Rep. 8, A-05; Reaffirmed: BOT Rep. 8, A-08; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15

FDA Regulation of Tobacco Products H-495.988

1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health,
and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of reduced nicotine content tobacco products and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.

2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

3. Our AMA: (A) will continue to monitor the FDA's progress towards establishing a low nicotine product standard for tobacco products and will submit comments on the proposed rule that are in line with the current scientific evidence and (B) recognizes that rigorous and comprehensive post-market surveillance and product testing to monitor for unintended tobacco use patterns will be critical to the success of a nicotine reduction policy.

Whereas, Our AMA is pursuing strategic goals of improving health outcomes for patients, as well as improving physician satisfaction; and

Whereas, As part of the above strategic goals, abolishing the dysfunction in healthcare that compromises a patient’s need to receive care at the right place, at the right time, and in the most appropriate and cost-effective setting and a physician’s ability to provide same should be integral to this initiative; and

Whereas, Some medical centers have an “auto accept” policy where the center will unconditionally accept a patient with an emergent and/or serious condition for care, without consideration of the center’s capacity to appropriately care for that patient; and

Whereas, Such a blanket “auto accept” policy may in some instances compromise patient safety and/or overtax staff capabilities; and

Whereas, In the opinion of many, such policies place profit ahead of patient and staff welfare; therefore be it

RESOLVED, That our AMA takes the position that a decision on whether a medical center will adopt an “auto accept” policy (i.e., unconditional acceptance for care of a patient), including what limitations should apply, be taken only after a review procedure is defined, after medical and logistic study, by an entity independent of the medical facility’s administration (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for a center’s independent medical staff to be an integral party as to whether an “auto accept” policy (i.e., unconditional acceptance for care of a patient) should be adopted, with what limitations, and if so, what form of implementation should be instituted, given the proposed policy’s impact on patient safety and care quality. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/10/2019

RELEVANT AMA POLICY: None identified.
Whereas, Hospitals and other health care facilities traditionally use their websites to inform the public of all their physicians on staff; and

Whereas, More and more hospitals and other health care facilities are employing more and more physicians; and

Whereas, A growing trend of these hospitals and health care facilities is removing their voluntary staff physicians from their websites and ‘Find a Doctor’ sites and listing only their employed physicians; and

Whereas, Patients searching for a physician on these websites but not finding the voluntary physicians may assume the physician is not on staff, retired, or not credentialed; therefore be it

RESOLVED, That our American Medical Association advocate for regulation and/or legislation requiring all credentialed physicians (employed and voluntary) be equally included on the websites and Find a Doctor sites of the hospitals and other health care facilities. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/02/2019

RELEVANT AMA POLICY: None identified.
Whereas, Drug shortages remain an ongoing public health crisis in the United States; and
Whereas, Our AMA has excellent policy to evaluate and make recommendations of national
drug shortages (H-100.956); and
Whereas, The Council on Science and Public Health Report 2-A-19\(^1\) points out that the rate of
new medical product shortages is increasing and shortages of essential medications are
severely impacting patient care and pharmacy operations; and
Whereas, in the Council on Medical Service Report 8-A-19\(^2\), the Council points out that the drug
shortage issue is multi-factorial and complex and the causes of these shortages continue to
remain largely unchanged, including quality problems, limited inventory, regulatory approval,
production complexity, and constrained manufacturing capability; and
Whereas, New manufacturers may not be able to quickly enter the market to produce a drug
which is in shortage because U.S. Food and Drug Administration (FDA) approval is required
and existing manufacturers need FDA approval of changes to manufacturing conditions or
processes; and
Whereas, the letter\(^3\) from the AMA to FDA Commissioner Dr. Scott Gottlieb in the Council on
Scientific and Public Health Report 2-A-19 is accurate and the AMA should strongly support the
FDA’s efforts to provide increased flexibilities and engagements when manufacturers have
notified the agency of potential or actual drug shortages; and
Whereas, The National Transportation and Safety Board assigns a team of investigators
immediately after an aircraft accident happens, the FDA could provide an equivalent response
when drug shortages are made known to the agency; therefore, be it
RESOLVED, That our AMA urge the FDA to create a rapid response team to expedite, in a safe
manner, the regulatory approval for new and existing manufacturers of pharmaceuticals when
the FDA has been notified of a potential or actual drug shortage. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/04/2019

References:
RELEVANT AMA POLICY:

National Drug Shortages H-100.956

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.

2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.

3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

6. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.

7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.

11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and provide more detailed information regarding the causes and anticipated duration of drug shortages.

12. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.

13. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.

14. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.


Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.

3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

7. Our AMA supports legislation to shorten the exclusivity period for biologics.

8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.

9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.

10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand,
or specialty) by 10% or more each year or per course of treatment and provide justification for
the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade
Commission to take legal action to address price gouging by pharmaceutical manufacturers and
increase access to affordable drugs for patients; and (c) the expedited review of
generic drug applications and prioritizing review of such applications when there is
a drug shortage, no available comparable generic drug, or a price increase of 10% or more
each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications
when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of
state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical
products where manufacturers engage in anti-competitive behaviors or unwarranted price
escalations.

Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17;
OMSS Governing Council Report A identifies resolutions and reports relevant to medical staffs that have been submitted for consideration by the AMA House of Delegates (HOD) at the 2019 AMA Interim Meeting. This report is submitted to the Assembly to facilitate the instruction of the OMSS Delegate and Alternate Delegate regarding the positions they should take in representing the Section in the HOD.

The following recommendations regarding OMSS positions on HOD resolutions and reports are presented for the consideration of the Assembly:

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<td>CEJA Report 01 – Competence, Self-Assessment and Self Awareness</td>
<td>Based on the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed: The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills. However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their</td>
<td>1. That the OMSS Delegate be instructed to support the intent of CEJA Report 1-I-19.</td>
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<td>professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.</td>
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<td>To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:</td>
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<td>(a) Cultivate continuous self-awareness and self-observation.</td>
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<td>(b) Recognize that different points of transition in professional life can make different demands on competence.</td>
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<td>(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.</td>
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<td>(d) Seek feedback from peers and others.</td>
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<td>(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest.</td>
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<td>(f) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness.</td>
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<td>(g) Intervene in a timely, appropriate, and compassionate manner when a colleague’s ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician responsibilities to impaired colleagues.</td>
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<td>Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.</td>
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<td>Res 203 – Support of Expansion of Good Samaritan Laws</td>
<td>RESOLVED, That our AMA amend Policy D-95.977 by addition and deletion to read as follows: 911 Good Samaritan Laws, D-95.977</td>
<td>2. That the OMSS Delegate be instructed to support the intent of Resolution 203-I-19.</td>
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<td>(Medical Student Section)</td>
<td><strong>Our AMA:</strong> (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan Laws. <em>(Modify Current HOD Policy)</em></td>
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<td><strong>Res. 206 – Improvement of Healthcare Access in Underserves Areas by Retaining and Incentivizing IMG Physicians</strong> <em>(International Medical Graduates Section &amp; Minority Affairs Section)</em></td>
<td><strong>RESOLVED,</strong> That our American Medical Association support efforts to retain and incentivize international medical graduates serving in federally designated health professional shortage areas after the current allocated period. <em>(Directive to Take Action)</em>.</td>
<td>3. That the OMSS Delegate be instructed to support the intent of Resolution 206-I-19.</td>
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<td><strong>Res. 214 – AMA Should Provide a Summary of Its Advocacy Efforts on Surprise Medical Bills</strong> <em>(New York)</em></td>
<td><strong>RESOLVED,</strong> That our American Medical Association Board of Trustees provide a detailed report of its efforts and those of allies and opponents around the issue of surprise medical bills in 2019; this discussion should include the following points comparing the AMA and partners activity vs that of its opponents (the insurance companies): 1) What testimony was provided at various committee meetings? 2) What letters were written to various legislators? 3) What grass roots efforts were performed? 4) What other groups supported the efforts 5) What other groups were recruited to support the efforts? 6) What media efforts were performed? 7) What television ads were run? 8) What radio ads were run? 9) What print ads were run? 10) What op-ed pieces were run, in national journals, Washington journals, and regional publications? 11) What meetings occurred with various legislators? 12) What meetings occurred with members of the administration? 13) How much money was spent on the various efforts?</td>
<td>4. That the OMSS Delegate be instructed to support the educational intent of Resolution 206-I-19, but question the resolution’s workload direction to the AMA’s Board of Trustees.</td>
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<td>Res. 215 – Board Certification of Physician Assistants (American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery, Society for Investigative Dermatology, American Society of Dermatopathology, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American College of Emergency Physicians, Iowa, Maryland, Wisconsin, Virginia, Florida, International Society of Hair Restoration Surgery, Arizona)</td>
<td>RESOLVED, That our American Medical Association amend Policy H-35.965, “Regulation of Physician Assistants,” by addition and deletion to read as follows: Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; and (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by independent organizations to board certify physician assistants in a manner that misleads the public to believe such certification is equivalent to medical specialty board certification. (Modify Current HOD Policy); and be it further RESOLVED, That our AMA amend Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as follows Our AMA: 1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety. 2. Opposes any action, regardless of intent, by independent organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety. 3. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining</td>
<td>5. That the OMSS Delegate be instructed to support the intent of Resolution 214-I-19.</td>
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<td>Res. 217 – Promoting Salary Transparency Among Veterans Health Administration Employed Physicians (Women Physicians Section)</td>
<td>RESOLVED, That our American Medical Association encourage physician salary transparency within the Veterans Health Administration. (Directive to Take Action)</td>
<td>6. That the OMSS Delegate be instructed to support the intent of Resolution 217-I-19.</td>
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<td>Res. 218 – Private Payers and Office Visit Policies (American College of Rheumatology, American Academy or Neurology, American Association of Clinical Endocrinologists, Endocrine Society, North American Neuro-Ophthalmology Society)</td>
<td>RESOLVED, That our American Medical Association with all haste directly engage and advocate with commercial insurance companies that discontinue payment for consultation codes or that are proposing to or considering eliminating payment for such codes, requesting that the companies reverse or delay such policy changes while the Centers for Medicare and Medicaid Services (CMS) updates its approach to valuation of office visits (Directive to Take Action); and be it further RESOLVED, That if in the CY 2020 Medicare physician fee schedule final rule CMS finalizes its proposal to increase payments for evaluation and management services, then our American Medical Association will advocate publicly and with all private payers that those private payers mirror and follow CMS’ lead in more appropriately valuing office visits, by increasing payments for evaluation and management services in their reimbursement schedules. (Directive to Take Action)</td>
<td>7. That the OMSS Delegate be instructed to support the intent of Resolution 218-I-19.</td>
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| C       | CME Report 03 – Standardization of Medical Licensing Time Limits Across States | 1. That our American Medical Association (AMA) urge the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams to allow sufficient time for individuals who are pursuing combined degrees (e.g, MD/PhD). (New HOD Policy)  
2. That our AMA urge that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances. (New HOD Policy)  
3. That our AMA encourage uniformity in the time limit for completing the licensing examination sequence across states, allowing for improved inter-state mobility for physicians. (New HOD Policy) | 8. That the OMSS Delegate be instructed to support the intent of CME Report 03-I-19. |
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<td>Res. 305 – Ensuring Access to Safe and Quality Care for Our Veterans (Young Physicians Section)</td>
<td>RESOLVED, That our American Medical Association amend AMA Policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows: Ensuring Access to Safe and Quality Care for our Veterans H-510.986 1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans. 2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner. 3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans. 4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration. 5. Our AMA supports access to similar clinical educational resources for all health care professionals involved in the care of veterans as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans. 6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed. (Modify HOD Policy)</td>
<td>9. That the OMSS Delegate be instructed to support the intent of Resolution 305-I-19.</td>
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<td>CMS Report 02 – Addressing Financial Incentives to Shop for Lower-Cost Health Care</td>
<td>1. That our American Medical Association (AMA) support the following continuity of care principles for any financial incentive program (FIP): Collaborate with the physician community in the development and implementation of patient incentives. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care. Provide treating physicians with access to patients’ FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.</td>
<td>10. That the OMSS Delegate be instructed to support the intent of CMS Report 2-I-19.</td>
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<td>Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service. Provide referring and/or primary care physicians with the full record of the service encounter. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan). Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans. (New HOD Policy)</td>
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<td>2. That our AMA support the following quality and cost principles for any FIP: Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician’s quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians. Provide a process through which patients and physicians can publicly report unsatisfactory care experiences with referred lower-cost physicians or facilities. Provide meaningful transparency of prices and vendors. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs. (New HOD Policy)</td>
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<td>CMS Report 03 – Improving Risk Adjustment in Alternative Payment Models</td>
<td>That our American Medical Association (AMA) reaffirm Policy H-385.908 stating that the AMA will work with the Centers for Medicare &amp; Medicaid Services and interested organizations to design systems that identify data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient’s health and success of treatment, such as disease stage and socio-demographic factors; account for differences in patient needs, such as functional limitations, changes in medical conditions, and ability to access health care services; and explore an approach in which the physician managing a patient’s care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification. (Reaffirm HOD Policy) That our AMA reaffirm Policy D-478.995 advocating for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records so that</td>
<td>11. That the OMSS Delegate be instructed to support the intent of CMS Report 3-I-19.</td>
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<td>Res. 809 – AMA Principles of Medicaid Reform (Utah)</td>
<td>RESOLVED, That our American Medical Association support the following principles of Medicaid reform: 1. Provide appropriate access to care that is the most cost effective and efficient to our citizens. 2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible. 3. Create the best coverage at the lowest possible cost. 4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services. 5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care.</td>
<td>12. That the OMSS Delegate be instructed to seek referral for Resolution 809-I-19.</td>
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<td>Res. 810 – Hospital Medical Staff Policy</td>
<td>6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care. 7. Assure appropriate payment and positive incentives to encourage but not require clinician participation in Medicaid for both face-to-face and non-face-to-face encounters, under appropriate establishment of clinician-patient relationship. 8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours. 9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health. 10. Eliminate current disincentives (e.g., Medicaid spend-down in order to qualify) to patients improving their lives while on Medicaid, to increase successful transition into the private insurance market. 11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid. 12. Develop a physician directed clinician oversight board at the state level to insure the proper access, quality and cost of care under the Medicaid program throughout all geographically diverse areas of the states. 13. Allow clinicians to see patients for more than one procedure in a visit so that patients do not have to return for another service at an extra cost to the Medicaid program and extra time and effort to the Medicaid patient (e.g., if patient comes because they are sick, allow them to have a diabetes check-up at the same time). 14. Strategically plan to reduce administrative costs and burdens to clinicians, and of the Medicaid program itself, by reducing at least, but not limited to, burdensome documentation requirements, administrative obstacles, and regulatory impediments. (New HOD Policy) and be it further RESOLVED, That our AMA pursue action to improve the federal requirements for Medicaid programs based on the AMA’s principles of Medicaid reform (Directive to Take Action)</td>
<td>RESOLVED, That our American Medical Association support and advocate that hospital medical staff leadership should be fully licensed physicians and that if others are included, they should be non-voting or advisory to the hospital medical staff members (Directive to Take Action); and be it further RESOLVED, That our AMA support and advocate that the decisions made by hospital medical staffs focus on quality patient care, medical staff standards and the operation of</td>
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<td>the hospital, and that those decisions not engage the medical staff in external political matters (e.g., advanced practice clinician scope of practice expansion, etc.). (Directive to Take Action); and be it further RESOLVED, That AMA Policy H-225.993, “Medical Staff Policy Determination,” be rescinded. (Rescind HOD Policy)</td>
<td>14. That the OMSS Delegate be instructed to support the intent of Resolution 811-I-19.</td>
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<td>K</td>
<td>CSAPH Report 01 – Mandatory Reporting of Diseases and Conditions</td>
<td>That our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal funding to modernize our nation’s public health data systems to improve the quality and timeliness of data; (5) supports electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting. (New HOD Policy)</td>
<td>15. That the OMSS Delegate be instructed to support the intent of CSAPH Report 1-I-19.</td>
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<td>Res. 904 – Amendment to AMA Policy H-150.949, “Healthy Food Options in Hospitals” (Medical Student Section)</td>
<td>RESOLVED, That our AMA encourage the availability of healthy, plant-based options at medical care facilities by amending AMA Policy H-150.949, “Healthy Food Options in Hospitals,” by addition and deletion to read as follows: Healthy Food Options in Hospitals, Medical Care Facilities, H-150.949 1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital the premises of Medical Care Facilities.</td>
<td>16. That the OMSS Delegate be instructed to support the intent of Resolution 904-I-19.</td>
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2. Our AMA hereby calls on all US hospitals and Correctional Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.

3. Our AMA hereby calls for Medical Care Facility cafeterias and inpatient meal menus to publish nutrition information. (Modify Current HOD Policy)

K  Res. 912 – Improved Emergency Response Planning for Infectious Disease Outbreaks (Young Physicians Section)

RESOLVED, That our American Medical Association encourage hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery (Directive to Take Action); and be it further

RESOLVED, That our AMA support flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage health departments to develop public health messaging to provide education on unexpected infectious disease. (Directive to Take Action)

17. That the OMSS Delegate be instructed to support the intent of Resolution 912-I-19.

The following recommendations regarding OMSS positions on the Green Report are presented for the consideration of the assembly:

. Con  CEJA Report 02 – Amendment to E-1.2.2, In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, “Discrimination against Physicians by Patients,” be rescinded;

18. That the OMSS express concern over the conclusions of CEJA Report 2-I-19 and that the
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<td>“Disruptive Behavior by Patients”</td>
<td>Opinion 1.2.2, “Disruptive Behavior by Patients,” be amended by addition and deletion as follows; and the remainder of this report be filed:</td>
<td>Report be sent back to CEJA for further work.</td>
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<td>The relationship between patients and physicians is based on trust and should serve to promote patients’ well-being while respecting their dignity and rights of both patients and physicians.</td>
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<td>Disrespectful, derogatory, prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either physicians or patients can undermine trust and compromise the integrity of the patient-physician relationship. It can make members of targeted groups reluctant to seek or provide care, and create an environment that strains relationships among patients, physicians, and the health care team.</td>
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<td>Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:</td>
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<td>(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those they target who are targeted.</td>
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<td>(b) Always treat patients with compassion and respect.</td>
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<td>(c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient’s behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.</td>
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<td>(d) In general, decline to accommodate patient requests for an alternative physician when the request is solely the product of prejudice against the physician’s personal characteristics.</td>
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<td>(e) Consider accommodating a patient’s request for an alternative physician when the request derives from the patient’s adverse personal experience, doing so would promote effective care, and another appropriately qualified physician is available to provide the needed care.</td>
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| K       | CSAPH Report 03 – Patient Use of Non-FDA Approved Cannabis and Cannabis-derived Products in Hospitals | (f) In emergency situations, patients who persist in opposing treatment from the physician assigned may be helped to seek care from other sources. When transfer is not feasible, patients should be informed that care will be provided by appropriately qualified staff independent of the patient’s expressed preference.  
(eg) Terminate the patient-physician relationship with a patient who uses derogatory language or acts in a prejudiced manner whose volitional behavior is disrespectful, derogatory, or prejudiced only if the patient will not modify the conduct. In such cases, the physician should arrange to transfer the patient’s care when that is feasible.  
Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:  
(h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.  
(i) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.  
(j) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients.  
(k) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community. | 19. That the OMSS Delegate be instructed to support the intent of CSAPH Report 3-I-19. |
on patient use of non-FDA approved cannabis or cannabis-derived products within their facilities, to ensure clinicians are prepared to treat patients in accordance with policy. (New HOD Policy)

The following items are of interest for the consideration of the OMSS, but for which the Governing Council does not offer a recommendation:

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<td>B</td>
<td>Res. 201 – Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities (Medical Student Section)</td>
<td>RESOLVED, That our American Medical Association advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care. (Directive to Take Action)</td>
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<td>B</td>
<td>Res. 219 – QPP and the Immediate Availability of Results in CEHRTS (American Society of Clinical Oncology)</td>
<td>RESOLVED, That our American Medical Association urge the Centers for Medicare &amp; Medicaid Services to create guardrails around the “immediate” availability of laboratory, pathology, and radiology results, factoring in an allowance for physician judgement and discretion regarding the timing of release of certain results (Directive to Take Action); and be it further RESOLVED, That our AMA encourage vendors to implement prompts that give physicians the ability to either approve notes to just the chart or approve and publish them in both the chart and patient portal. (Directive to Take Action)</td>
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<td>J</td>
<td>Res 804 – Protecting Seniors from Medicare Advantage Plans (Indiana)</td>
<td>RESOLVED, That our American Medical Association encourage AARP, insurance companies and other vested parties to develop simplified tools and guidelines for comparing and contrasting Medicare Advantage plans. (New HOD Policy)</td>
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<td>K</td>
<td>Res. 913 – Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use</td>
<td>Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use RESOLVED, That our American Medical Association work with interested organizations to collate existing worldwide data on the public health impacts, societal impacts, and unintended consequences of legalization and/or</td>
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<td>Cannabis for Medicinal and Recreational Use (Young Physicians Section)</td>
<td>decriminalization of cannabis for recreational and medicinal use, with a report back at the 2020 Interim Meeting (Directive to Take Action); and be it further</td>
<td>RESOLVED, That our AMA continue to encourage research on the unintended consequences of legalization and decriminalization of cannabis for recreational and medicinal use in an effort to promote public health and public safety (Directive to Take Action); and be it further</td>
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<td>RESOLVED, That our AMA encourage dissemination of information on the public health impacts of legalization and decriminalization of cannabis for recreational and medicinal use, with consideration of making links to that information available on the AMA website (Directive to Take Action); and be it further</td>
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<td>RESOLVED, That our AMA work with interested organizations to lobby Congress to allow more sites to conduct research on the risks and benefits of cannabinoid products. (Directive to Take Action)</td>
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EXECUTIVE SUMMARY

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

To fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients. As a profession, medicine should provide meaningful opportunity for physicians to hone their ability to be self-reflective.
The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the AMA Code of Medical Ethics [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

Yet despite the centrality of competence to professionalism, the Code has not hitherto examined what the commitment to competence means as an ethical responsibility for individual physicians in day-to-day practice. This report by the Council on Ethical and Judicial Affairs (CEJA) explores this topic to develop ethics guidance for physicians.

DEFINING COMPETENCE

A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional assessments of physicians’ technical knowledge and skills. However, this report is not concerned with matters of technical proficiency assessed by medical schools and residency programs, specialty boards (for purposes of certification), or hospital and other health care organizations (e.g., for privileging and credentialing). Such matters lie outside the Council’s purview.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. For purposes of this analysis, competence is understood as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served” and as “developmental, impermanent, and context dependent” [10].

Moreover, the Council is keenly aware that technical proficiency evolves over time—what is expected of physicians just entering practice is not exactly the same as what is expected of mid-career physicians or physicians who are changing or re-entering practice or transitioning out of...
active practice to other roles. Each phase of a medical career, from medical school through
to retirement, carries its own implications for what a physician should know and be able to do to
practice safely and to maintain effective relationships with patients and with colleagues.

The concept that informs this report differs as well from the narrower definition of competence as
the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion
of competence that encompasses deeper aspects of wisdom, judgment and practice that enable
physicians to assure patients, the public, and the profession that they provide safe, high quality care
moment to moment over the course of a professional lifetime.

FROM SELF-ASSESSMENT TO “INFORMED” SELF-ASSESSMENT

Health care institutions and the medical profession as a whole take responsibility to regulate
physicians through credentialing and privileging, routinely testing knowledge (maintenance of
certification, requirements for continuing education, etc.) and, when needed, taking disciplinary
action against physicians who fail to meet expectations for competent, professional practice.
However, the better part of the responsibility to maintain competence rests with physicians’
“individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs
to maintain a level of competence commensurate with [their] clinical roles” [11].

Self-assessment has thus become integral to many appraisal systems [5, 10, 12-16]. Yet clinicians
and trainees tend to assess their peers’ performance more accurately than they do their own—for
example, those who perform in the bottom quartile tend to over-estimate their abilities, while those
in the top quartile tend to under-estimate themselves [5,12,13,17].

Self-assessment involves an interplay of factors that can be complicated by personal characteristics
(e.g., gender, ethnicity, or cultural background); by lack of insight or ability to be self-observant in
the moment; and by external factors, such as the purpose of self-assessment [12,18]. The published
literature also indicates that interventions intended to enhance self-assessment may seek different
goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting
appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

Thus self-assessment tools alone are not sufficient measures of physicians’ ability to provide safe,
high quality care. Feedback from third parties is essential [19]. However, physicians can be hesitant
to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of
concern that soliciting feedback could adversely affect their relationships with those whom they
approach [20]. They may also question the accuracy and credibility of the assessment process and
the data it generates [21]. And they are not sure how to use information that is not congruent with
their self-appraisals [20].

To be effective, feedback must be valued by those being assessed as well as by those offering
assessment [14]. When there is tension between the stated goals of assessment and the implicit
culture of the health care organization or institution, assessment programs can too readily devolve
into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20].
Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews
(“360° reviews”), for example, are generally better suited to providing feedback on communication
and interpersonal skills than on technical knowledge or skills—and easy for evaluators to
understand and use [14]. High quality feedback will come from multiple sources; be specific and
focus on key elements of the ability being assessed; address behaviors rather than personality or
personal characteristics; and “provide both positive comments to reinforce good behavior and
constructive comments with action items to address deficiencies” [22]. Beyond such formal
mechanisms, physicians should welcome and seek out informal input from colleagues. They should be willing to offer timely comments to colleagues as well.

One study among physicians and trainees found that participants interpreted and responded to multiple types of information, such as cognitive and affective data, from both formal and informal sources [23]. Participants described “critically reflecting ‘in action,’ that is, during an activity or throughout the day”:

> I think we do a lot of it without thinking of it as reflection. We do it every day when we look at a patient’s chart. You look back and see the last visit, “What did I do, or should I have done something different?” I mean that’s reflection, but yet I wouldn’t have thought of that as self-assessment or self-reflection, but we do it dozens of times a day [23].

EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians’ thought processes are as important as their knowledge base or technical skills. Thus, understanding competence requires understanding something of the nature of expertise and processes of expert reasoning, themselves topics of ongoing exploration [24,25,26,27].

Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s] automatic resources and to transition appropriately to a greater reliance on effortful processes when needed” [24], a practice described as “slowing down.” Knowing when to slow down and be reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To respond to the unexpected events that often arise in a clinical situation, the physician must “vigorously monitor relevant environmental cues” and use these as signals to slow down, to transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should” serves as a critical marker for intraoperative surgical judgment [24].

Influences on Clinical Reasoning

Physicians’ skills of clinical reasoning develop through education, training, and experiences. Every physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or differ from the analytical and investigative processes of their colleagues in innumerable ways. Nonetheless, all physicians are susceptible to certain common pitfalls in reasoning, notably relying unduly on heuristics and habits of perception, and succumbing to overconfidence.

Physicians use time-saving cognitive short cuts (heuristics) to help identify and categorize relevant information. But such short cuts can also mislead physicians to mis categorize information based on seeming similarity or to place too much weight “on examples of things that come to mind easily [28]. Other common cognitive missteps can derail clinical reasoning as well, including misperceiving a coincidental relationship as a causal one, or the tendency to remember information transferred at the beginning or end of an exchange but not information transferred in the middle [28,29,30].

Like every other person, physicians can also find themselves prone to conscious or unconscious habits of perception or biases. They may allow unquestioned assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health behavior, for example, to shape how they perceive the patient and how they engage with, evaluate, and treat the individual [31]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or
dismiss contradicting information that does not fit into predetermined beliefs [28]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.

So too, despite their extensive training, physicians, like all people, are often poor at identifying the gaps in their knowledge [28,30]. They may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [30]. Overconfidence in one’s abilities can lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one’s limits [28,30].

Physicians should be aware of the information they do and do not have and they acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [28]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming aware of areas in which their skills are not at their strongest and seeking additional education or consulting with colleagues, physicians can enhance their practice and best serve their patients.

FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [32]. Self-assessment, it is suggested, is a mechanism for identifying both one’s weaknesses and one’s strengths. One should be aware of one’s weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that “should be accepted as forever outside one’s scope of competent practice” [32]. Knowing one’s strengths, meanwhile, allows a physician both to “act with appropriate confidence” and to “set appropriately challenging learning goals” that push the boundaries of the physician’s knowledge [32].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in the moment is critical to physicians’ ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Self-awareness, in the form of attentive self-observation, alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to “slow down” during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [25].
Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [34,35], by disrupting memory processes, particularly the “prospective memory”—i.e., “a memory performance in which a person must recall an intention or plan in the future without an agent telling them to do so”—important for resuming interrupted tasks [35,36]. Systems-level interventions have been shown to help reduce the number or type of interruptions and distractions and mitigate their impact on medical errors [37].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being at the boundaries of one’s knowledge and responding accordingly [33]. Slowing down, looking things up, consulting a colleague, or deferring from taking on a case can all be appropriate responses when physicians’ self-awareness tells them they are at the limits of their abilities. The capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of competence broadly understood:

Safe practice in a health professional’s day-to-day performance requires an awareness of when one lacks the specific knowledge or skill to make a good decision regarding a particular patient . . . . This decision making in context is importantly different from being able to accurately rate one’s own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of self-efficacy and ongoing ‘reflection-in-practice,’ addressing emergent problems and continuously monitoring one’s ability to effectively solve the current problem [32].

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills [32]. Self-aware physicians are also alert to how external stressors— the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

Physicians’ ability to be sufficiently self-aware to practice safely can be compromised by illness, of course. In some circumstances, self-awareness may be impaired to the point that individuals are not aware of, or deny, their own health status and the adverse effects it can or is having on their practice. In such circumstances, individuals must rely on others—their personal physician, colleagues, family, social acquaintances, or even patients—to help them recognize and address the situation. Physicians have a responsibility to one another and to patients to promote health within the physician community, a responsibility that extends to intervening when a colleague’s ability to practice safely is compromised [E-9.3.2]. Physicians who are unable to recognize that they are impaired due to cognitive disability or other illness are not necessarily blameworthy or unethical, unless they decline to address their condition and modify their practice once others have drawn attention to their inability to continue practicing medicine safely.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their professional careers. This ideal holds not just over the course of a sustained clinical practice, but equally when physicians re-enter practice after a hiatus, transition from active patient care to roles as educators or administrators, or take on other functions in health care. Self-assessment and self-awareness are central to achieving that goal.
A variety of strategies is available to physicians to support effective self-assessment and help them cultivate the kind of self-awareness that enables them to “know when to slow down” in day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in the form of written descriptions, audio or video recording, or photos of encounters with patients that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike standardized examinations, they are drawn from one’s actual work and require self-reflection [15].

As noted above, to be effective, self-assessment must be joined with input from others. Well-designed multi-source feedback can be useful in this regard, particularly for providing information about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple response that elicits feedback about how well one maintains trust and professional relationships with patients, one’s communication and teamwork skills, and accessibility offers a valid, reliable tool that can have practical value in helping to correct poor behavior and, just as important, consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful feedback will not have the rigor of a validated tool but can accomplish similar ends.

Reflective practice, that is, the habit of using critical reflection to learn from experience, is essential to developing and maintaining competence across a physician’s practice lifetime [38]. It enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional culture,” and to bridge new and existing knowledge. Studies suggest that reflective thinking can be assessed, and that it can be developed, but also that the habit can be lost over time with increasing years in practice [38].

“Mindful practice”—being fully present in everyday experience and aware of one’s own mental processes (including those that cloud decision making) [39]—sustains the attitudes and skills that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on behavior over consciousness, erects barriers to mindful practice, while an individual’s unexamined negative emotions, failure of imagination, and literal-mindedness can do likewise. Physicians can cultivate mindfulness in myriad ways; e.g., through meditation, keeping a journal, reviewing videos of encounters with patients, or seeking insight from critical incident reports [39].

“Exemplary physicians,” one scholar notes, “seem to have a capacity for self-critical reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values” [39].

RECOMMENDATION

Based on the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.

However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should
know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

(a) Cultivate continuous self-awareness and self-observation.

(b) Recognize that different points of transition in professional life can make different demands on competence.

(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.

(d) Seek feedback from peers and others.

(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest.

(f) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness.

(g) Intervene in a timely, appropriate, and compassionate manner when a colleague’s ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician responsibilities to impaired colleagues.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500.
REFERENCES

Whereas, In 2016, drug overdoses killed 63,632 Americans, the leading cause of preventable death in the USA; and

Whereas, Opioid overdose can be effectively reversed using the opioid antagonist naloxone; and

Whereas, Between 21-68% of overdose bystanders call 911, but many delay or refrain from calling 911 altogether often due to fear of arrest; and

Whereas, 46 states have passed some form of a “Good Samaritan Law” (GSL) as endorsed by our AMA (D-95.977) to provide limited immunity from drug-related offenses to people who seek medical assistance in the event of an overdose; and

Whereas, Many people who use drugs are not aware these laws exist, one study found that two-thirds of those surveyed were unaware of GSLs; and

Whereas, A study in New York found that bystanders with a correct understanding of GSLs were three times more likely to call 911 in the event of an overdose than those who had incorrect knowledge about GSLs; and

Whereas, GSLs provide variable legal protection by state, which may confer protection against prosecution for specific crimes such as the possession of illicit/controlled substances, paraphernalia, and/or parole/pretrial/probation violations; and

Whereas, A drug-induced homicide is defined as a crime in which a person delivered or provided drugs to another person that resulted in their death; and

Whereas, GSLs do not provide protections for drug-induced homicide; and

Whereas, Only Vermont and Delaware have specific laws that provide immunity for drug-induced homicide if a person seeks medical assistance; and

Whereas, Some states have enacted “911 Medical Amnesty Laws” to protect individuals from arrest, prosecution or conviction of certain drug offenses if the evidence results from seeking medical assistance for someone thought to be suffering from a drug overdose; and

Whereas, The enactment of aforementioned medical amnesty policies in cases of underage drinking have been shown to not increase consumption; and
Whereas, As of 2016, 40 states had implemented medical amnesty laws protecting minors in alcohol related emergencies; and

Whereas, Implementation of Medical Amnesty Protocols (MAP) did not result in increased drinking, overall consumption, or the incidence of physiological consequences; and

Whereas, After the creation of MAP, Cornell students showed an increased willingness to seek help for alcohol related emergencies, and there was a 61% decrease in the students who cited fear of getting in trouble as the reason they did not call for help; and

Whereas, The number of prosecutions of drug-induced homicide across the country has increased over 300% since 2011, with the Midwest accounting for a large portion of this increase; family members, friends, and partners are the frequent victims of these prosecutions; and

Whereas, Increases in drug-induced homicide prosecutions are correlated with increases in fatal overdose rates and studies suggest this may be due to increased fear of calling for help; and

Whereas, Research suggests that a lack of Good Samaritan laws can lead to conditions in which there are higher opioid-related deaths and decreased medical interventions--representing a real public health concern; therefore be it

RESOLVED, That our American Medical Association amend Policy D-95.977 by addition and deletion to read as follows:

911 Good Samaritan Laws, D-95.977
Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan Laws. (Modify Current HOD Policy)

Fiscal note: Minimal - less than $1,000

Received: 08/28/19

References:


RELEVANT AMA POLICY

911 Good Samaritan Laws D-95.977
Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level.

Citation: (Res. 225, A-14)

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18

Harm Reduction Through Addiction Treatment H-95.956
The AMA endorses the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction, and the AMA will work toward the implementation of such an approach nationwide. The AMA affirms that addiction treatment is a demonstrably viable and efficient method of reducing the harmful personal and social consequences of the
inappropriate use of alcohol and other psychoactive drugs and urges the Administration and Congress to provide significantly increased funding for treatment of alcoholism and other drug dependencies and support of basic and clinical research so that the causes, mechanisms of action and development of addiction can continue to be elucidated to enhance treatment efficacy.

Citation: (Res. 411, A-95; Appended: Res. 405, I-97; Reaffirmation I-03; Reaffirmed: CSAPH Rep. 1, A-13)

**Increasing Availability of Naloxone H-95.932**

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.

2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.

3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.

4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.

5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.

6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.

7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.

8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.

9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19

**Support for Medical Amnesty Policies for Underage Alcohol Intoxication H-30.938**

Our AMA supports efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment for underage drinking when seeking emergency medical attention for themselves or others.

Citation: (Res. 202, A-12)
Whereas, One in four of the practicing physician workforce in the United States of America are trained at an international medical school; and

Whereas, 41% of the international medical graduates (IMG) serve in the primary care disciplines, as defined by the Association of American Medical Colleges (AAMC), including internal medicine, family medicine, pediatrics and geriatrics; and

Whereas, An American Medical Association and American Osteopathic Association database study showed that the IMGs are more likely to serve in the rural persistent poverty areas in primary care, compared to their U.S. counterparts and DOs; and

Whereas, By 2030, an estimated shortage of between 14,800 and 49,300 primary care physicians has been projected by a recent American Association of Medical Colleges report; and

Whereas, The U.S. population aged over 65 is estimated to grow over 50% by 2030 and one third of the currently active physicians will be older than 65 in the next decade; and

Whereas, If people in the underserved and rural areas and people without insurance would use healthcare the same way as the people with insurance and the people in the metropolitan areas; an additional 31,600 physicians were needed in 2016; and

Whereas, Critical access hospitals in underserved areas continue to face a crisis due to uncompensated care and limited retention of physicians; and

Whereas, The residents of the rural and underserved areas tend to be older, more chronically ill, of a lower socioeconomic background and uninsured, resulting in significant disparities in rural and urban health care status and life expectancy; and

Whereas, The overall number of U.S. medical graduates choosing careers as general internist has declined over many years and retention of general practice physicians remained a persistent challenge in improving health care access in these areas; and
Whereas, A current Conrad 30 Reauthorization Bill (Senate Bill S948) has proposed a pathway for IMGs to serve in the federally designated health professional shortage area (HPSA) with a majority of Medicare/Medicaid and uninsured population for a longer duration, an increased number of IMGs to be available in each state to serve in these areas and have incentives to serve and settle in these areas; therefore be it

RESOLVED, That our American Medical Association support efforts to retain and incentivize international medical graduates serving in federally designated health professional shortage areas after the current allocated period. (Directive to Take Action).

Fiscal Note: Minimal - less than $1,000

Received: 10/01/19


RELEVANT AMA POLICY

US Physician Shortage H-200.954

Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health
centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.


Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution’s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these
efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties—particularly those practicing in underserved urban or rural areas—should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these
and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
Citation: CME Rep. 04, I-18

**Improving Rural Health H-465.994**

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

2. Our AMA will work with other entities and organizations interested in public health to:
   - Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
   - Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
   - Study efforts to optimize rural public health.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19
Whereas, There has recently been very significant legislative activity in regards to surprise medical bills and balance billing, critically important issues for physicians; and

Whereas, Insurance companies have tried to use the issue of surprise medical bills to essentially outlaw all physician billing, which would be devastating to the medical profession; and

Whereas, The AMA goal of improved physician satisfaction with professional activity is enhanced by supporting various modes of practice; and

Whereas, Coordination of messaging and engagement of various organizations is critical to success in our advocacy efforts on behalf of our members, patients, and profession; and

Whereas Member and non-member engagement should be improved by a better understanding of our efforts; therefore be it
RESOLVED, That our American Medical Association Board of Trustees provide a detailed report of its efforts and those of allies and opponents around the issue of surprise medical bills in 2019; this discussion should include the following points comparing the AMA and partners activity vs that of its opponents (the insurance companies):

1) What testimony was provided at various committee meetings?
2) What letters were written to various legislators?
3) What grass roots efforts were performed?
4) What other groups supported the efforts
5) What other groups were recruited to support the efforts?
6) What media efforts were performed?
7) What television ads were run?
8) What radio ads were run?
9) What print ads were run?
10) What op-ed pieces were run, in national journals, Washington journals, and regional publications?
11) What meetings occurred with various legislators?
12) What meetings occurred with members of the administration?
13) How much money was spent on the various efforts?
14) What studies were published in insurance journals, medical journals, and other journals on this matter?
15) Which senators and representatives and administration members could either side count on as solid supporters?
16) What level of collaboration was there with other national, state, and specialty societies and how was this carried out? (Directive to Take Action)

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

Received: 10/04/19
Whereas, In 2019, state legislatures considered over 1,000 bills seeking to expand the scope of practice of non-physicians; and

Whereas, Physician assistants sought legislation consistent with elements of the optimal team practice act, which was adopted by the American Academy of Physician Assistants. While many states attempted to remove direct physician supervision or allow PAs to perform certain functions without physician supervision, most of the legislation was defeated or made minimal change in practice; and

Whereas, Physician assistants are a valuable member of the physician-led team; and

Whereas, Physician assistants complete a 26-month physician assistant program followed by 2,000 hours of clinical rotations, which emphasize primary care in ambulatory clinics, physician offices and acute or long-term care facilities; and

Whereas, After finishing a rigorous undergraduate academic curriculum, physicians receive an additional four years of education in medical school, followed by 3-7 years of residency and 12,000-16,000 hours of patient care training; and

Whereas, There are substantial differences in the education of physician assistants and physicians, both in depth of knowledge and length of training; and

Whereas, According to four nationwide surveys, 84% of respondents prefer a physician to have primary responsibility for diagnosing and managing their health care, and 91% of respondents said that a physician’s years of medical education and training are vital to optimal patient care, especially in the event of a complication or medical emergency; and

Whereas, A recent survey conducted by the American Medical Association’s Scope of Practice Partnership confirms increasing patient confusion regarding the many types of health care providers - including physicians, nurses, physician assistants, technicians and other varied providers. The survey revealed that 55 percent of patients believe it is difficult to identify who is a licensed medical doctor and who is not by reading what services they offer, their title and other licensing credentials in advertising or other marketing materials; and
Whereas, An organization independent of the National Commission on Certification of Physician Assistants is providing board certification exams for physician assistants working within dermatology; and

Whereas, This certification can deceive the public and allow physician assistants to advertise themselves as being “board certified;” and

Whereas, This can lead to significant patient safety issues; therefore be it

RESOLVED, That our American Medical Association amend Policy H-35.965, “Regulation of Physician Assistants,” by addition and deletion to read as follows:

Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; and (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies’ authority and purview; and (3) opposes efforts by independent organizations to board certify physician assistants in a manner that misleads the public to believe such certification is equivalent to medical specialty board certification. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as follows

Our AMA:

1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2. Opposes any action, regardless of intent, by independent organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.

3. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/16/19
RELEVANT AMA POLICY

Regulation of Physician Assistants H-35.965
Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; and (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies’ authority and purview.

Citation: Res. 233, A-17

Physician Assistants H-35.989
1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.
3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician’s office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.
4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the
patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.

5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.

6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.

7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.


Medical Specialty Board Certification Standards H-275.926

Our AMA:

1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.

3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.

5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15
Whereas, Gender inequities among health care providers exist and are receiving increasing scrutiny; and

Whereas, Inequities may be associated with a lack of mentors, discrimination, gender bias, imposter syndrome, and difficulties with work-life balance; and

Whereas, Pay disparities exists as an example of gender inequity; and

Whereas, Pay disparity impacts women’s morale and their ability to attain economic stability; and

Whereas, Pay disparity also creates barriers to workforce participation for women, slowing the growth of the U.S. economy, according to a Brookings Institute study;¹ and

Whereas, Following a steady increase between 1950-1999, female U.S. labor force participation rates began to decline in the next decade;² and

Whereas, Most recent data demonstrate male physicians earn 9 to 40 percent more than female physicians, controlling for age, experience, specialty, faculty rank, and clinical revenue;³ and

Whereas, This leads to an estimated $36K-$95K annual difference in earnings; and

Whereas, Pay scales should be easily quantifiable metrics and therefore ready targets for intervention to improve equity; and

Whereas, There are no published data regarding Veterans Health Administration physician pay differences; therefore be it

RESOLVED, That our American Medical Association encourage physician salary transparency within the Veterans Health Administration. (Directive to Take Action)

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

Received: 10/08/19
References:

RELEVANT AMA POLICY

**Principles for Advancing Gender Equity in Medicine H-65.961**

Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one’s career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Citation: BOT Rep. 27, A-19;

**Advancing Gender Equity in Medicine D-65.989**

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

Citation: Res. 010, A-18; Modified: BOT Rep. 27, A-19;

Inequity in Military Pay for Physicians D-40.993
Our AMA will work, as appropriate, with other interested organizations, to support immediate reintroduction of a bill based on H.R. 5353 (107th Congress) in this Congress.

Citation: (BOT Action in response to referred for decision Res. 901, I-03; Reaffirmed: BOT Rep. 28, A-13)
WHEREAS, Recently commercial payers have implemented policies for evaluation and management (E/M) services that discontinue payments for consultations, in that they will deny claims billed with CPT codes for consultation services as not valid; and

WHEREAS, Consultation is requested by primary care and other referring physicians to address patients’ most challenging and complex medical problems, and this work often includes extensive review of prior records as well as communication and coordination with referring providers. The expertise of the consulting physician is often cost-saving to the insurance carrier, as these specialists can often diagnose and treat the condition without ordering unnecessary tests or treatments; and

WHEREAS, Failing to acknowledge the difference in work between a consultation and the relative simplicity of assuming the care of a patient with a known diagnosis is misguided and will predictably limit the ability of providers to consult on complex cases; and

WHEREAS, When the Centers for Medicare and Medicaid Services discontinued payment for consultation codes in 2010, the medical community raised significant concerns because in its decision the agency failed to recognize the expertise and additional collaboration that is reflected in the use of consultation codes; and

WHEREAS, In its CY 2020 Medicare physician fee schedule proposed rule the Centers for Medicare and Medicaid services proposed adopting the American Medical Association RUC Update Committee (RUC) recommended values for the office and outpatient evaluation and management (E/M) visit codes for CY 2021, which would more appropriately value complex E/M services; and

WHEREAS, Given that healthcare policy makers are moving toward a more appropriate valuation of office visits and E/M services, it is alarming that commercial payers would move to stop recognizing consultation services at this time; therefore be it

RESOLVED, That our American Medical Association with all haste directly engage and advocate with commercial insurance companies that discontinue payment for consultation codes or that are proposing to or considering eliminating payment for such codes, requesting that the companies reverse or delay such policy changes while the Centers for Medicare and Medicaid Services (CMS) updates its approach to valuation of office visits (Directive to Take Action); and be it further
RESOLVED, That if in the CY 2020 Medicare physician fee schedule final rule CMS finalizes its proposal to increase payments for evaluation and management services, then our American Medical Association will advocate publicly and with all private payers that those private payers mirror and follow CMS' lead in more appropriately valuing office visits, by increasing payments for evaluation and management services in their reimbursement schedules. (Directive to Take Action)

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

Received: 10/17/19

RELEVANT AMA POLICY

Consultation Codes and Private Payers D-385.955
1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.
2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.
Citation: Res. 819, I-17

Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953
1. Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.
Citation: Res. 807, I-09; Appended: Sub. Res. 212, I-10; Reaffirmation A-12; Appended: Res. 216, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-17
Subject: Standardization of Medical Licensing Time Limits Across States  
(Resolution 305-A-18)

Presented by: Jacqueline A. Bello, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 305-A-18, introduced by the American Medical Association Medical Student Section (AMA-MSS), asked that our AMA:

Amend Policy H-275.978, “Medical Licensure,” by addition to read as follows:

The AMA… (23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX.

Testimony before Reference Committee C at the 2018 Annual Meeting was in favor of referring this complex item for further study. Some states have no time limit for completion of the licensing examination sequence; some set a time limit of seven years; and some cap eligibility at 10 years (to accommodate the longer timeline for dual-degree individuals, e.g., those seeking to hold MD and PhD credentials). Testimony was heard concerning the perception that physicians who have academic troubles will take longer to complete the sequence, such that the time limit becomes a mechanism through which to ensure patient safety by eliminating these individuals from the practice of medicine. This belief, however, does not take into account the legitimate health or personal issues that may affect a given physician’s ability to complete all exams within a prescribed timeframe, or the challenges faced by those pursuing dual degrees. Testimony in favor of a time limit was that this would ensure that examinees are being assessed based on their current medical knowledge. Accordingly, the AMA House of Delegates referred this item, to ensure a comprehensive, holistic review and study of all the relevant factors and consideration of potential unintended consequences, with the involvement of all relevant stakeholders, such as the Federation of State Medical Boards (FSMB) and the 70 state medical and osteopathic regulatory boards it represents.

BACKGROUND

State medical boards are entrusted to protect the public from unprofessional, unlawful or incompetent physician behavior. To ensure that physicians practicing in a state or jurisdiction are minimally competent to provide patient care, physicians under the board’s purview are required to complete either the United States Medical Licensing Examination (USMLE), for allopathic medical school graduates, or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA), if a graduate of an osteopathic medical college. Passage of the USMLE or the COMLEX-USA is necessary to be eligible for a full and unrestricted license to practice medicine. Both the USMLE and COMLEX-USA are composed of a series of exams. Most students studying medicine
in the U.S. take the first three exams while in medical school; the final exam is typically taken while the physician is in residency training.

Current U.S. Licensing Completion Requirements

States may have different requirements as to the number of attempts to pass the exams, as well as different limits that cap the length of time for completion. Furthermore, many states allow for more time if the physician is pursuing a dual-degree (e.g., MD-PhD), and may also waive the time limit in the event of extenuating circumstances. Although many states have similar requirements, there is no universal standard, and there is great variability between MD and DO boards within states (for USMLE and COMLEX-USA, respectively) and between states. Table 1 presents data from the FSMB on the 66 licensing boards in the states, District of Columbia, and Puerto Rico. Some states’ responses regarding extenuating circumstances are omitted due to lack of clarity.¹

Table 1. U.S. medical boards’ USMLE or COMLEX-USA completion time limits

<table>
<thead>
<tr>
<th></th>
<th>No limit</th>
<th>7 years</th>
<th>8 years</th>
<th>9 years</th>
<th>10 years</th>
<th>12 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>USMLE</td>
<td>10</td>
<td>28</td>
<td></td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>COMLEX-USA</td>
<td>22</td>
<td>14</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD/DO-PhD/dual degree</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>14</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Although 23 of reporting boards with a time limit for completion will waive the limit depending on extenuating circumstances, 12 will not; these 12 have the time limits as shown in Table 2.

Table 2. USMLE or COMLEX-USA completion and dual-degree time limits of U.S. medical boards that do not waive time limits

<table>
<thead>
<tr>
<th>Number of boards</th>
<th>USMLE/COMLEX-USA limit</th>
<th>Dual-degree limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>7 years</td>
<td>—</td>
</tr>
<tr>
<td>2</td>
<td>10 years</td>
<td>—</td>
</tr>
<tr>
<td>1</td>
<td>7 years</td>
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<tr>
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<td>10 years</td>
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<td>10 years</td>
<td>10 years</td>
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<tr>
<td>1</td>
<td>10 years</td>
<td>12 years</td>
</tr>
</tbody>
</table>

The two maps present time limits for USMLE and COMLEX-USA completion. Although some contiguous states have identical requirements, many do not. For example, four of the five states bordering New York—which has no time limit for completion of USMLE—require completion within seven years.
Data from the National Board of Medical Examiners (NBME), the organization that administers the USMLE, suggests that most physicians pass the three steps of the USMLE within seven years of starting the process (91 percent); 99 percent complete the USMLE within 10 years. These data are for U.S. medical school graduates of schools accredited by the Liaison Committee on Medical Education (LCME) and do not include graduates of foreign medical schools or graduates of osteopathic medical schools.\(^2\) Similarly, the National Board of Osteopathic Medical Examiners (NBOME), which administers the COMLEX-USA, has found the average time from the initial attempt of the Level 1 examination to completion of COMLEX-USA with passage of Level 3 to be 2.81 years. In addition, less than 0.2% of candidates who passed Level 3 between 2015 and 2019 took longer than seven years.\(^3\)

In a study examining the performance of over 40,000 Step 3 examinees, Feinberg et al. reported that 55 percent of examinees took the Step 3 exam within six to 18 months of starting residency, 93 percent tested within 36 months of training, and 99 percent had tested within 60 months of starting training.\(^4\)

**Patient Safety and Workforce Issues**

The purpose of passing the USMLE and the COMLEX-USA is to ensure the public that a physician has met a standard of medical knowledge and clinical skills to provide safe and effective patient care. There have been studies examining the association between USMLE performance and 1) demographic characteristics of physicians\(^5\) and 2) academic performance, remediation, and referral to a competency committee while in medical school,\(^6,7\) among other studies. Much is unknown, however, about USMLE/COMLEX-USA performance and state medical licensure. In a study that found an association between physicians’ unprofessional behavior noted during medical school and subsequent disciplinary actions by state medical licensing boards, there was no statistical association with Step 1 score and subsequent disciplinary action.\(^8\) A study by Cuddy et al. that included Step 1, Step 2 CK scores, and state medical licensure data on over 164,000 physicians found that higher Step 2 CK scores were associated with a decreased chance of disciplinary action.\(^9\)

Actions taken by state medical licensure boards are, by default, taken against physicians who have completed the medical licensure process. As Cuddy et al. point out: “Physicians who fail the USMLE are unable to obtain a license to practice medicine in the United States, thus precluding the possibility of establishing whether or not physicians who have met USMLE standards provide better patient care than those who have failed to meet these standards.”\(^9\) It is not known if physicians who do not become licensed as a result of not completing the licensure process within the time required, or ever, would pose a risk to patient safety—linkages have been made between poor performance on exams and academic performance in medical school and state disciplinary actions. It can be assumed that failing the exams is an indicator of compromised physician competency.

Physician-scientists, or physicians who pursue PhDs as well as clinical training, are an important workforce in biomedical research; however, they likely take longer to become licensed, an accommodation recognized by 21 state licensing boards. Typically, around 550 physicians graduate each year with an MD-PhD, taking approximately eight years to receive both degrees.\(^10\)

When considering time-limit exceptions for completing the USMLE sequence in the case of dual-degree physicians, the NBME recommends state licensing boards waive the time limit for candidates meeting the following requirements:

- The candidate has obtained both degrees from an institution or program accredited by the LCME and a regional university accrediting body.
• The PhD should reflect an area of study which ensures the candidate a continuous involvement with medicine and/or issues related, or applicable to, medicine.

• A candidate seeking an exception to the seven-year rule should be required to present a verifiable and rational explanation for the fact that he or she was unable to meet the seven-year limit. These explanations will vary, and each licensing jurisdiction will need to decide on its own which explanation justifies an exception. Students who pursue both degrees should understand that while many states’ regulations provide specific exceptions to the seven-year rule for dual-degree candidates, others do not. Students pursuing a dual degree are advised to check the state-specific requirements for licensure listed by the FSMB.11

The NBME has had discussions with its Advisory Committee for Medical School Programs concerning dual-degree candidates and their potential need for more time to complete the licensure sequence than some states may permit. Within those discussions, however, the committee was not able to identify a qualified dual-degree candidate who was denied state licensure based on exceeding a state time-limited rule for passing USMLE.2

What is not known is how many physicians are delayed in completing the USMLE or COMLEX-USA sequence due to life circumstances, including taking a leave of absence to care for a family member or for other personal situations. Physicians who do not become licensed can pursue careers in health-related fields but will not be able to practice medicine. At a time when physician workforce shortages are predicted, lack of state licensure resulting solely from circumstances that did not permit a physician to complete the USMLE or COMLEX-USA sequence within a given time limit seems improvident.

Advantages to Nationwide Uniformity

Medical licensing boards vary greatly in their regulations concerning the number of times physicians can take the different Step or Level exams, the length of time to complete the sequence for single- or dual-degree physicians, and whether exceptions can be made for qualifying extenuating circumstances. States that are contiguous can have very different requirements. Yet, once a physician is licensed in one jurisdiction, and is in good standing, another licensing board is not likely to weigh the length of time the physician required to complete the exam sequence in the initial location against the physician if he or she is seeking a license to practice in a new state. Without data suggesting qualitative differences in the competency of physicians who become licensed in seven versus 10 years, or even longer, there may be few valid arguments for time limits except as an external source for motivation to complete the task—although the ability to independently practice medicine should be the most compelling motivation.

RELEVANT AMA POLICY

The appendix shows relevant AMA policy, including H-275.955, “Physician Licensure Legislation” and D-275.994, “Facilitating Credentialing for State Licensure.”

SUMMARY AND RECOMMENDATIONS

There is geographic mobility among physicians, particularly soon after completing residency or in pursuing a fellowship, and crossing state lines is likely. Ensuring uniformity in the time requirement in which to become fully licensed would remove one regulatory burden for young physicians when mapping out their career and future practice location. Furthermore, an acknowledgement of, and accommodation for, the many life events that can affect the ability to study for and take the required
exams may potentially allow for greater diversity among the physician workforce. Lastly, providing the extra time that dual-degree physicians need in order to complete both degrees and become fully licensed will ensure that this vital workforce is fully integrated into both research and clinical realms.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 305-A-18 and the remainder of this report be filed:

1. That our American Medical Association (AMA) urge the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams to allow sufficient time for individuals who are pursuing combined degrees (e.g, MD/PhD). (New HOD Policy)

2. That our AMA urge that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances. (New HOD Policy)

3. That our AMA encourage uniformity in the time limit for completing the licensing examination sequence across states, allowing for improved inter-state mobility for physicians. (New HOD Policy)

Fiscal note: $1,000.
APPENDIX: RELEVANT AMA POLICY

H-275.955, “Physician Licensure Legislation”

Our AMA reaffirms earlier policy urging licensing jurisdictions to adopt laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for the endorsement of licenses to practice medicine, and to base endorsement of medical licenses on an assessment of competence rather than on passing a written examination of cognitive knowledge.

D-275.994, “Facilitating Credentialing for State Licensure”

Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.
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2 Michael Barone, MD, National Board of Medical Examiners. Personal communication, August 7, 2019.

3 Joseph Flamini, MBA, National Board of Osteopathic Medical Examiners. Personal communication, August 13, 2019.


7 Hemann BA, Durning SJ, Kelly WF, Dong T, Pangaro LN, Hemmer PA. The Association of students requiring remediation in the internal medicine clerkship with poor performance during internship. *Military Medicine.* 2015; 180, April Supplement. doi: 10.7205/MILMED-D-14-00567


11 USMLE. [https://www.usmle.org/frequently-asked-questions/#general](https://www.usmle.org/frequently-asked-questions/#general). Accessed August 6, 2019
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-19)

Introduced by: Young Physicians Section

Subject: Ensuring Access to Safe and Quality Care for our Veterans

Referred to: Reference Committee C

Whereas, Studies have identified barriers related to physicians not employed by the Veterans Administration (VA) and their ability to care for veterans as patients in addressing veterans’ status and addressing the military associated needs of this population; and

Whereas, Training of VA physicians require completion of educational modules for addressing specific veteran needs; and

Whereas, Recognition and treatment of these needs can be taught through the Talent Management System 2.0 modules such as Veterans Health Administration Mandatory Training for Trainees, Military Sexual Trauma, Traumatic Brain Injury, and Suicide Awareness Voices of Education (SAVE)-Suicide; and

Whereas, The availability of similar training resources could help physicians not employed by the VA provide better care for veterans; therefore be it

RESOLVED, That our American Medical Association amend AMA Policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:

Ensuring Access to Safe and Quality Care for our Veterans H-510.986

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.

2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.

3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.

4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.

5. Our AMA supports access to similar clinical educational resources for all health care professionals involved in the care of veterans as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.

6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed. (Modify Current HOD Policy)
RELEVANTAMA POLICY:
Ensuring Access to Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

Citation: Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15; Modified: Res. 820, I-18

References:

Fiscal Note: Minimal - less than $1,000
Received: 09/26/19
REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-19)
Addressing Financial Incentives to Shop for Lower-Cost Health Care
(Reference Committee J)

EXECUTIVE SUMMARY

The Council on Medical Service presents this report to examine the practice of employers and insurance companies increasingly implementing programs (i.e., Financial Incentive Programs or FIPs) that offer patients financial incentives when they use shopping tools to compare prices on health care items and services and choose lower-cost options. This report examines the potential benefits and risks of FIPs, analyzes examples of current FIPs, and offers guidance on how FIPs could be improved.

Virtues of FIPs include promoting price transparency, empowering patients to pursue health care that minimizes financial burden and reducing societal health care costs. At the same time, it is critical that patients be empowered to make fully informed decisions about their health care, that they are never coerced into accepting lower-cost care if it could jeopardize their health, and that programs that influence patient decision-making be equally transparent about quality and cost. To protect patient access to high-quality care, the Council recommends a set of guiding principles that it encourages health care payers (employers, insurance companies, etc.) and third-party vendors to incorporate into the design and implementation of FIPs. These guiding principles focus on protecting physician involvement in FIPs, the patient-physician relationship, quality assurance and transparency, and patient choice. To further promote these ideals, the Council recommends that the American Medical Association (AMA) encourage state medical associations and national medical specialty societies to seek opportunities to collaborate in the design and implementation of FIPs to empower physicians and patients to make high-value referral choices, and to encourage objective studies of the impact of FIPs.
While encouraging patients to pursue lower-cost health care, employers and insurance companies are increasingly implementing programs (ie, Financial Incentive Programs or FIPs) that offer patients financial incentives when they use shopping tools to compare prices on health care items and services and choose lower-cost options. The Council on Medical Service presents this Council-initiated report to examine the emergence and impact of FIPs, as well as the potential benefits and risks of FIPs, and to offer guidance on how FIPs could be improved.

BACKGROUND

Care can be deemed “shoppable” when it is a common service that can be researched in advance, multiple providers of that service are available in a market, and sufficient data about the prices and quality of services are available. Estimates vary as to what proportion of health care spending can be deemed “shoppable,” with some estimates at 10 percent, and others as high as 33 to 43 percent.

FIPs appeal to employers and insurers because they encourage patients to price shop without exposing them to increased out-of-pocket costs. Additional virtues of FIPs include promoting price transparency, empowering patients to pursue health care that minimizes financial burden and reducing societal health care costs. While considering these potential benefits of FIPs, it is critical to ensure that patients are empowered to make fully informed decisions about their health care, that they are never coerced into accepting lower-cost care if it could jeopardize their health, and that programs that influence patient decision-making be equally transparent about quality and cost.

FIPs in the private sector can be used by employers as part of employee benefit packages, or health insurance companies can implement FIPs for their enrollees. In the public sector, some states have implemented FIPs as part of state employees’ benefits. The Council discusses various models that have emerged to encourage and assist patients shopping for lower-cost health care. The models vary with respect to the level of voluntary versus potentially coercive impact on patients. With this report, the Council emphasizes the protection of patients and the patient/physician relationship; and recommends a series of principles to address the potential of FIPs to further fragment patient care.

POTENTIAL BENEFITS AND RISKS OF FIPs

Potential Benefits

FIPs could benefit patients, payers, and the health care system in several ways. Both underinsurance and cost-related non-adherence pose significant challenges to patients and providers. Even when a service is covered by a health plan, patients may incur significant costs in

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the form of co-payments, coinsurance, and/or large medical bills that they must pay before meeting their deductible. Such costs have been shown to cause people, especially those in low-income and vulnerable populations, to forgo necessary care. Similarly, cost-related non-adherence refers to a state in which patients are unable to pursue recommended medical care due to financial barriers. For example, greater out-of-pocket costs for medication to treat certain chronic conditions have been found to reduce initiation and adherence, lower the likelihood of achieving desired health outcomes, and sometimes, increase utilization of acute care services. In contrast, studies have demonstrated that reducing or eliminating cost-sharing leads to improvements in medication adherence and reductions in socioeconomic and racial disparities. Accordingly, FIPs could potentially increase patients’ access to medical care that may have been financially out-of-reach for them. Additionally, when patients make cost-effective treatment choices, those savings can benefit payers and the health care system. Moreover, even if patients do not alter their treatment plans, having information about the cost of planned medical care provides much needed transparency. Finally, if the care being incentivized by FIPs is, in fact, high-quality care, these programs could be consistent with longstanding American Medical Association (AMA) policy supporting value-based insurance design, as an opportunity to align clinical and financial incentives for patients to pursue high-value care.

FIPs could also be significantly enhanced by including referring/prescribing physicians in the “shopping” experience at the point of care. Treating physicians’ referral recommendations play a critical role in patients’ choices regarding follow-up care. FIPs that embrace the importance of physician referrals could benefit patients, physicians and other elements of the health care system. If patients’ FIP benefits could be made available to treating physicians in real time during patient consultations, patients and their trusted physicians could work together to choose the best referral and/or prescription option, considering both quality and cost of care. Such fully informed referrals could enhance efficiency, quality, and cost of care.

Potential Risks

FIPs raise many questions that must be answered to determine whether they are truly in patients’ best interests. As an initial matter, FIPs raise several administrative questions. Health care is uniquely complex and cannot simply be shopped like retail goods. Key limits on shopping for health care include:

- **Patient Limits**: Even if a service is shoppable for some patients, for other patients, shopping for that service may not be convenient, practical or advisable. Similarly, prescription drugs can be shoppable in some cases, but not in others. Some patients find less expensive drugs just as efficacious as more expensive alternatives, but specific formulations are required by others. While some patients may find that a lower-priced prescription drug could be appropriate, it might require additional burden for the patient (such as more frequent dosing) and/or the provider (such as required monitoring and/or testing). In such cases, patients must fully understand and be willing to accept the additional burden.

- **Care Coordination and Quality of Care**: If shopping for lower-cost care leads patients to obtain care from a variety of physicians and facilities, absent an integrated records system, there is a potential for fragmentation of care, which creates additional challenges for patients and physicians in receiving and providing quality care.

- **Administrative Burden**: If, after receiving a referral or prescription from their physicians, patients shop for and choose to pursue lower-cost care, both the patients and their physicians may face time-consuming administrative burdens. Patients may need to reach out to their referring
physicians for new prescriptions and/or new referrals, and they may have to seek copies of their medical records to facilitate care coordination.

FIPs also raise concerns about quality of care and unintended consequences, and these become especially fraught when working with already vulnerable patient populations, such as those with low incomes and/or costly chronic conditions, who may be unduly persuaded by enticing financial incentives. Here the question of whether patients are truly presented with meaningful choices versus the extent to which they are somewhat coerced into accepting a non-preferred care option becomes more complicated. Key considerations include continuity of care and the tradeoff between quality and cost.

**Continuity of Care:** It is unclear whether FIPs will interfere in patient-physician relationships and/or attempt to substitute for medical advice. Patients should be empowered to reach out to whomever they would like in researching their care options. However, if patients have received referrals or prescriptions from their physicians and have not made efforts to shop for alternative options, programs that proactively reach out to such patients to suggest alternative courses of treatment risk harming the trust built between patients and their physicians and risk substituting their judgement for medical advice. Additionally, it is not clear how the “health professionals” providing patient assistance through some FIPs are trained, but even if providing referrals is within their scope of practice, these “health professionals” could disrupt existing patient-physician relationships.

**Quality/Cost Tradeoffs:** Any program that encourages physicians or patients to make quality trade-offs to reduce cost raises significant questions about unintended consequences. While some care, even if that care is of less than ideal quality, could be better than cost-related non-adherence, the obvious preference is to direct patients to appropriate care while minimizing financial burden. For patients experiencing significant financial burden, either due to expensive medical conditions or due to other social determinants of health, it is especially important to acknowledge and safeguard against crossing the fine line between an optional financial incentive and implicit coercion to accept the least expensive care.

While the FIPs described in this report claim to base their decisions on care quality, it is not clear what metrics or data are used to evaluate quality, nor is it clear if their metrics align with well-established, evidence-based quality criteria developed by national medical specialty societies. Accordingly, it is possible that these programs could steer patients to care that is of lesser quality than the original physician referral. Transparency regarding FIPs quality data and analyses is essential.

**INTRODUCTION TO CURRENT FIPs**

Generally, shopping programs are available through preferred provider organization (PPO)-style plans that offer patients broader choices of providers from whom they can receive care. Patients enrolled in Health Maintenance Organizations (HMOs) and/or narrow-network plans are restricted to a smaller set of medical providers and may be unable to access higher quality and lower cost health care. Additionally, patient cost-sharing varies significantly based on insurance benefit design, and some design features will provide greater or lesser incentives for patients to shop for lower-cost care.

The decision to implement an FIP can come from the private and/or public sector. In the private sector, employers can choose to implement FIPs as part of their employees’ benefits packages, or health insurance companies can implement FIPs for their enrollees. In the public sector, some
states have chosen to implement FIPs as part of state employees’ benefits packages (eg, New Hampshire) or via legislation that requires some private insurers to offer pay-to-shop incentives (eg, Maine). Multiple tools have emerged to encourage and assist patients shopping for a broad spectrum of care.

Sapphire Digital: More than 350 health plans and employers, representing over 95 million members, use the Sapphire Digital platform to incentivize patients to shop for care. Sapphire Digital’s SmartShopper program works by integrating directly with an employer’s benefit program. SmartShopper reaches patients through several channels: call centers, web chat assistants, direct mail campaigns, and an online platform where patients can compare prices. SmartShopper is aimed at patients, but it requires partnerships with local providers, employers, and payers. The FIP provides cash incentives to encourage patients to shop for what the company describes as “routine care” including, imaging services, labs, specialty drugs, preventive exams and outpatient surgeries. The extent to which these services are truly routine, however, is subjective. Approximately 200 procedures can be shopped through the SmartShopper program, with about 50 services being responsible for the bulk of the savings. After comparing prices, if patients choose to receive care from one of the identified lower-cost providers, they will be mailed a check, with incentives on average ranging from $25 to $500 per individual service. In 2018, the most shopped medical procedures were lab/blood work, mammogram, magnetic resonance imaging (MRI), colonoscopy, and computerized tomography (CT) scan.

Critically, it is unclear what quality metrics Sapphire Digital uses to determine whether the lower-cost services it incentivizes are in fact “better value” and “high-quality.” Sapphire Digital provides shoppers with quality data from Quantros which has been described as, “a patent pending proprietary composite scoring system which integrates outcome quality measures, such as readmission, complication and mortality rates, into a single, multidimensional composite quality score. The data are risk-adjusted and rendered as an easy-to-understand rating for individual physicians, hospitals and health systems.” Previously, Sapphire Digital had described its quality data as incorporating “structure” and “patient experience” measures.

Sapphire Digital recently took health care shopping a step further when it launched its Medical Expertise Guide (MEG) in late 2018. MEG builds upon the SmartShopper tool in two critical ways: first, it focuses specifically on influencing patients’ choices for surgical procedures; and second, rather than relying on patients to engage with the tool because they are interested in shopping for care, MEG enables Sapphire Digital to predict which patients might need care and proactively reaches out to those patients. The program’s engagement strategy is based on predictive analytics and modeling, used to identify patients on a clinical path that could lead to expensive surgery. In describing their methods for identifying high-quality care, Sapphire Digital explains that MEG applies quality measures such as infection and complication rates, patient reviews, predictive analytics, and “proprietary confidence measures.” MEG also provides assistance from “highly-trained health care professionals.” This novel technology has the potential for both significant benefits and risks.

UnitedHealthcare (UHC): In addition to incentivizing patients to shop for lower-cost health care services, FIPs can incentivize patients to choose lower-cost prescription drugs. UHC recently launched its My ScriptRewards program that allows patients to earn up to $500 in prepaid debit cards that can be used to pay medical expenses when they choose “doctor-approved, guideline-recommended and cost-effective medications” to treat HIV. UHC explains that the Department of Health and Human Services (HHS) has recommended several HIV treatment regimens, and the cost among these regimens can vary significantly. UHC has selected two regimens (Cimduo® + Tivicay® (two-pill regimen) and Cimduo + Isentress®/Isentress HD® (three-pill regimen)) and
incentivizes patients to choose one of these lower-cost regimens by offering these regimens with no patient cost-sharing, plus the prepaid debit card rewards.

With the lower cost of UHC’s preferred regimens, however, come some key distinctions between UHC’s preferred HIV treatments and other options. Critically, HHS guidelines issued in late 2018 selected Biktarvy, a treatment that is not eligible for the UHC incentive, as a preferred regimen, whereas UHC’s preferred regimens do not appear on the list of HHS recommended initial treatments. Moreover, UHC’s preferred regimens require patients to take two or three pills a day, whereas Biktarvy is a once-a-day pill regimen. UHC does not explicitly force patients to accept one of the lower-cost prescription options and stresses the importance of patients working with their physicians to determine whether one of the lower-cost treatment regimens is right for them. However, if the lower-cost regimens are not appropriate, the only recourse is to reach out to UHC to determine which alternative regimens are covered under patients’ pharmacy benefits, and patients or providers may be forced to explicitly opt out of the My ScriptRewards program in order to fill a non-preferred antiretroviral prescription. UHC plans to expand its My ScriptRewards program to additional high-cost specialty drug categories in the future.

Walmart: In contrast to FIPs focused on identifying lower-cost care, some payers are creating financial incentives that preference demonstrated quality over cost. Concerned that employees were being misdiagnosed, leading to unnecessary surgery and spending, Walmart Inc., the nation’s largest private employer, created a program to encourage patients to go to specific imaging centers based on diagnostic accuracy, not price. Walmart employees do not have to choose a preferred imaging center, but if they do not, they pay additional cost-sharing. Walmart’s imaging program is aligned with its efforts over the past decade to create financial incentives for patients to obtain care at designated hospitals where it believes patients will achieve better results. As part of its Centers of Excellence program, Walmart has selected hospitals across the country that it believes have the expertise and resources to provide its members with the highest-quality care for several medical conditions, including various surgeries and cancer diagnoses. For many of these treatments, patients travel to one of the designated Centers of Excellence, where their care is covered 100 percent and travel and lodging costs are covered for the patient and a companion caregiver.

Anthem/UHC: A similar but clearly distinguishable insurance benefit design feature imposes prior authorization requirements and/or denies coverage when patients choose a higher-priced site of service. Such benefit design features jeopardize physician and patient choice. Anthem and UHC provide examples of this type of program. In addition to Anthem’s preapproval process to review the medical necessity of a non-emergency outpatient MRI or CT scan, an Anthem subsidiary also evaluates where the scan should be performed, and provides the requesting physician with a list of eligible imaging centers. Citing the “huge cost disparities for imaging services, depending on where members receive their diagnostic tests,” Anthem’s program ultimately prevents many patients from receiving MRIs and CT scans at hospital-owned, outpatient facilities, instead requiring them to use independent imaging centers. Similarly, starting in 2019, UHC began conducting site of care reviews, in addition to their prior authorization reviews, when specific advanced diagnostic imaging procedures are requested at an outpatient hospital setting (no additional review is required if the test is to be performed at a freestanding diagnostic radiology center or office setting).
IMPACT OF HEALTH CARE SHOPPING PROGRAMS

Objective Data

Despite the increasing popularity of FIPs, there is little objective evidence of their impact.35 A working paper from the National Bureau of Economic Research highlights the crucial role of the referring physician. The study suggests that rather than focusing on patient cost-sharing, payers could more effectively help patients pursue lower-cost health care services by providing price information to physicians and incentivizing them to make cost-efficient referrals.36 The study found that patients did not “shop” for care, even when the care at issue was a non-invasive MRI scan, when they were exposed to significant out-of-pocket costs, when they were provided ready access to a price transparency tool, and when they had the opportunity to reduce the price they would pay without traveling a long distance.37 Instead, the study found that referring physicians influence where patients will receive further care far more than patient exposure to out-of-pocket costs, with referring physician influence accounting for 51 percent of variance, and out-of-pocket cost exposure accounting for 2.4 percent of the variance.38 The data studied were comprised of insurance claims data provided by a large national insurer that covers tens of millions of lives annually and is active in all 50 states. However, the main analysis uses data from 2013. The study authors infer that given the weight patients ascribe to the advice of their referring physicians versus the influence of out-of-pocket cost in the context of a lower-limb MRI scan, patients are even less likely to actively price shop for more complex services. Supporting these conclusions, a 2016 analysis by the Health Care Cost Institute, which is funded in part by Aetna, Humana, Kaiser Permanente, and UHC, found only “modest” potential gains from the consumer price shopping aspect of price transparency efforts.39

In another recent study, the Health Care Service Corporation (the fourth-largest health plan in the United States) collaborated with academic researchers to analyze the impact of the SmartShopper program.40 Critically, this study did not examine any impacts on quality of care; rather, it was focused on financial impacts and changes in utilization. While the study identified some cost savings for employers and patients, the financial impact was limited.41 The study estimated a 5.2 percent reduction in annual spending on reward-eligible services, a savings of $2.3 million per year, or approximately $8 per patient per year. The study authors noted that, to receive a reward, patients may not be able to receive care from the provider their physician initially recommended, and patients may feel more comfortable seeking a second referral for imaging services, rather than invasive procedures. Moreover, switching providers is particularly complex for surgical procedures, and patients may be more concerned about quality of surgical services. Additionally, the study noted that the availability of lower priced providers may play a role in the results observed. The study authors suggested that the small reduction in utilization among patients in receipt of any reward eligible services could be due to patients using the price comparison tool, becoming aware of the still high out-of-pocket cost of reward eligible services, and choosing not to pursue care. The study concludes that while rewards programs are appealing to employers, they may not be the most effective way to reduce spending.

Another recent study specifically focused on quality of care variations that exist among sites of care providing MRIs.42 A first of its kind study analyzed MRI reports following complete lumbar MRI examinations of the same patient, performed at 10 different regional imaging centers, over a period of three weeks. All of the study centers had valid accreditation from the American College of Radiology. The study found “marked variability” in the reported interpretive findings and “an alarmingly high number” of interpretive errors in the MRI reports.43 Specifically, no interpretive findings were reported in all 10 MRI reports, and only 1 finding (out of 49 total findings) was reported in 9 out of 10 reports. Moreover, the high average miss rate across the examinations
means that important pathologies are routinely under detected, and the high false positive rates for specific pathologies indicate that some diagnostic findings may be routinely over detected. These findings have clear and critical implications for appropriate diagnosis and treatment. Moreover, since payers heavily rely on MRI reports during utilization and authorization review processes, an inaccurate diagnosis on MRI can lead to significant delays in appropriate care.\textsuperscript{44} In the context of incentive programs, knowing that such significant variation exists among equally accredited providers of a non-invasive imaging examination raises serious questions about the quality of care evaluations FIPs perform before making referral recommendations that may differ from the patient’s treating clinician.

\textit{Data from Sapphire Digital}

In contrast to the objective research studies that question the impact of patients shopping for lower-cost health care, Sapphire Digital claims its tools have achieved more significant cost savings across the continuum of care. As of 2018, Sapphire Digital claims that, over the course of four years, its program saved employers over $56 million, and employers paid $6.7 million in cash incentives to their employees.\textsuperscript{45} Sapphire Digital stated that, on average, patients save $606 per procedure shopped on SmartShopper. In 2016, Sapphire Digital published an analysis that extrapolated potential health care system wide savings of $17.6 billion on colonoscopies alone.\textsuperscript{46} Data provided by plans that have implemented SmartShopper can support Sapphire Digital’s claims. For example, HealthTrust, a non-profit organization that provides insurance benefits to public employees and began using SmartShopper in 2014, saved $1.5 million by the end of 2015, $2.8 million by the end of 2016, and $2.75 million in the first 10 months of 2017.\textsuperscript{47} However, despite increases in engagement, as of 2018, only 10 percent of HealthTrust members regularly used SmartShopper.

\textbf{AMA POLICY}

FIPs relate to a wide variety of AMA policy. Policy H-450.941 expresses the AMA’s uncompromising commitment to primacy of the patient-physician relationship free from intrusion from third parties. The policy specifically supports initiatives that protect patient access and that do not contain requirements that permit third party interference in the patient-physician relationship, and it strongly opposes attempts to steer patients towards certain physicians primarily based on cost of care factors. Policy H-450.947 sets forth extensive pay-for-performance principles and guidelines. Especially relevant elements of Policy H-450.947 include a focus on patient-centered, evidence-based care; allowances for variations in individual patient care based on a physician’s clinical judgement; providing proactive explanations of programs to the patients impacted; and programs that do not create conditions that limit access to improved care or directly or indirectly disadvantage patients and their physicians based on geographic, ethnic, cultural, or socioeconomic groups, their medical conditions, or the setting where care is delivered.

AMA policy regarding drug pricing also informs discussion of FIPs. Policy H-110.997 supports programs that contain the rising costs of prescription drugs, with caveats to ensure that physicians have input into such programs, that all patients have access to all prescription drugs necessary to treat their illnesses, and that physicians have the freedom to prescribe the most appropriate drug(s) and method(s) of delivery for individual patients. Policy H-125.991 guides drug formularies and therapeutic interchange, discouraging switching of therapeutc alternates in patients with chronic diseases who are stabilized on a drug therapy regimen, while encouraging mechanisms such as incentive-based formularies.
AMA policies on the patient-centered medical home underscore the patient/physician relationship as essential for maintaining continuity of care (Policies H-160.919 and H-160.918). In addition, the Council notes the relevance of AMA Policy H-450.937 regarding medical tourism, which advocates that employers, insurance companies, and other entities that facilitate or incentivize medical care outside the US adhere to several principles, including that such incentives must be voluntary and ensure continuity of care and necessary follow-up care.

AMA policy strongly supports value-based care. Policy H-110.986 provides principles to guide value-based pricing programs for pharmaceuticals, including: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable data; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; and (d) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion. Policy H-155.960 supports value-based decision-making and recognizes the role of physician leadership and importance of collaboration among physicians, patients, insurers, employers, unions, and government in successful cost-containment and quality-improvement initiatives. Policy D-185.979 supports value-based insurance design plans and encourages national medical specialty societies to collaborate with payers to promote alignment of patient financial incentives with utilization of high-value services. Policy H-185.935 guides use of reference pricing and supports consideration of reference pricing strategies for elective services for which there is evidence of a significant variation in cost that does not correspond to a variation in quality of care.

DISCUSSION

Patients, physicians, and health care payers alike benefit when it is possible to identify high-quality health care that minimizes patient financial burden and ensures continuity of care. With payers increasingly looking to FIPs as an avenue for reducing patient costs, it is essential that health care quality not be sacrificed in the process, and that fragmentation of care is minimized. To protect these and other critical elements of high-quality care, the Council recommends a set of guiding principles for use in the development and implementation of FIPs.

Physicians are committed to providing and helping their patients obtain evidence-based, high-quality, cost-effective care. Accordingly, patients will benefit if physicians are involved in the development and implementation of patient incentives. Physicians should also be consulted by FIPs to identify high-value referral options. FIP benefit information should be integrated into health care information technology with real-time access to empower patients and physicians to make optimal referral and prescription choices efficiently, reduce subsequent administrative burden, and promote improved quality and cost of care.

FIPs must avoid adding to the fragmentation of patient care by informing referring and/or primary care physicians when their patients have selected an FIP service and by providing a full record of the service encounter. In addition, it is critical that patient care plans are first developed and discussed between patients and their physicians. FIPs should make it clear that only the treating physician can determine whether a lower-cost option is appropriate. Patients should be encouraged to consult with their physicians prior to deviating from established patient care plans.

It is also essential that FIPs remind patients that they can choose their physician or facility, consistent with their health plan benefits. FIPs should provide transparency regarding the quality data they use in making referral recommendations so that patients and physicians can be confident that lower-cost care meets their quality expectations. Similarly, FIPs should provide transparency...
of their quality ratings of participating physicians and facilities and provide physicians with
directions for appealing exclusion from lists of preferred lower-cost physicians. The Council also
recommends that patients and physicians should have access to a process for publicly reporting
unsatisfactory care with FIP options.

FIPs should provide meaningful transparency of both prices and vendors. Patients should fully
understand any cost-sharing, other burdens or trade-offs, and incentives associated with receiving
care from FIP-preferred physicians and facilities.

To further promote the ideals articulated in the principles, the Council recommends that health
insurers that contract with FIPs should indemnify patients for any additional medical expenses that
result as follow-up in cases where the FIP service is inadequate, such as a scan that is not useful to
the referring physician. The insurer should cover the follow-up scan with no patient cost-sharing.
The Council also recommends that state and medical associations and national medical specialty
societies apply these principles and seek opportunities to collaborate in the design and
implementation of FIPs to empower physicians and patients to make high-value referral choices
and recommends objective studies of the impact of FIPs. With FIPs at the intersections of local
health care and nation-wide large employer benefit plans, as well primary care referrals to
specialists, the AMA and the Federation of Medicine have complementary roles to play in
promoting optimal patient care.

Finally, given the lack of data on the impact of current FIPs, the Council recommends objective
studies on various aspects of FIPs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder
of the report be filed.

1. That our American Medical Association (AMA) support the following continuity of care
principles for any financial incentive program (FIP):

   a) Collaborate with the physician community in the development and implementation of
      patient incentives.
   b) Collaborate with the physician community to identify high-value referral options based on
      both quality and cost of care.
   c) Provide treating physicians with access to patients’ FIP benefits information in real-time
      during patient consultations, allowing patients and physicians to work together to select
      appropriate referral options.
   d) Inform referring and/or primary care physicians when their patients have selected an FIP
      service prior to the provision of that service.
   e) Provide referring and/or primary care physicians with the full record of the service
      encounter.
   f) Never interfere with a patient-physician relationship (eg, by proactively suggesting health
      care items or services that may or may not become part of a future care plan).
   g) Inform patients that only treating physicians can determine whether a lower-cost care
      option is medically appropriate in their case and encourage patients to consult with their
      physicians prior to making changes to established care plans. (New HOD Policy)
2. That our AMA support the following quality and cost principles for any FIP:
   a) Remind patients that they can receive care from the physician or facility of their choice
      consistent with their health plan benefits.
   b) Provide publicly available information regarding the metrics used to identify, and quality
      scores associated with, lower and higher-cost health care items, services, physicians and
      facilities.
   c) Provide patients and physicians with the quality scores associated with both lower and
      higher-cost physicians and facilities, as well as information regarding the methods used to
      determine quality scores.
   d) Respond within a reasonable timeframe to inquiries of whether the physician is among the
      preferred lower-cost physicians; the physician’s quality scores and those of lower-cost
      physicians; and directions for how to appeal exclusion from lists of preferred lower-cost
      physicians.
   e) Provide a process through which patients and physicians can publicly report unsatisfactory
      care experiences with referred lower-cost physicians or facilities.
   f) Provide meaningful transparency of prices and vendors.
   g) Inform patients of the health plan cost-sharing and any financial incentives associated with
      receiving care from FIP-preferred, other in-network, and out-of-network physicians and
      facilities.
   h) Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives,
      may require them to undertake some burden, such as traveling to a lower-cost site of
      service or complying with a more complex dosing regimen for lower-cost prescription
      drugs. (New HOD Policy)

3. That our AMA support requiring health insurers to indemnify patients for any additional
   medical expenses resulting from needed services following inadequate FIP-recommended
   services. (New HOD Policy)

4. That our AMA oppose FIPs that effectively limit patient choice by making alternatives other
   than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively
   must choose the FIP choice. (New HOD Policy)

5. That our AMA encourage state medical associations and national medical specialty societies to
   apply these principles in seeking opportunities to collaborate in the design and implementation
   of FIPs, with the goal of empowering physicians and patients to make high-value referral
   choices. (New HOD Policy)

6. That our AMA encourage objective studies of the impact of FIPs that include data collection
   on dimensions such as:
   a) Patient outcomes/the quality of care provided with shopped services;
   b) Patient utilization of shopped services;
   c) Patient satisfaction with care for shopped services;
   d) Patient choice of health care provider;
   e) Impact on physician administrative burden; and
   f) Overall/systemic impact on health care costs and care fragmentation. (New HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


Medicare and other payers are shifting away from the fee-for-service (FFS) model toward alternative payment models (APMs). A goal of APMs is to better deliver high quality care in a cost-efficient manner to improve outcomes. APMs can eliminate barriers to care coordination that are often present in traditional payment systems. For example, FFS generally does not support the resources that would be required to take after-hours calls from patients to help them avoid emergency visits; provide self-management education to help patients manage their conditions at home; or conduct proactive outreach to ensure patients get needed preventive services.

Often, the complex FFS patient will have additional insurance claims filed for their additional needed services. APMs that pay for services in a more aggregated way, such as a bundled payment for an episode of care or a monthly payment for each patient, need to have a means of adjusting payments to account for patients that need more services. Risk adjustment can serve as a tool to make APM payments better reflect differences in patient characteristics and need for services.

It is important to note that risk adjustment is distinct from both the assumption of financial risk and risk associated with professional liability. In an APM with downside financial risk, APM providers may be accountable for providing care within a capped payment amount and need to either absorb or repay spending in excess of that amount. Risk adjustment, the focus of this report, is a mechanism for adjusting payment rates, budgets, or both, based on the health status and expected spending on a patient population. Improved risk adjustment models will have positive spillover effects in other areas of payment policy, importantly in the Merit-based Incentive Payment System (MIPS), which adjusts FFS payments up or down according to performance in four categories. Similar to APMs, MIPS scores should be risk adjusted to account for variations in patient complexity, sociodemographic factors, and costs outside of the physician’s control. As many small and specialty practices will stay in MIPS, better risk adjustment is needed to avoid unfairly penalizing those who care for the sickest and most vulnerable.

This report, initiated by the Council, provides background on risk adjustment; outlines refinement strategies; summarizes relevant policy; details American Medical Association (AMA) work on adjustment improvements; and presents policy recommendations to improve risk adjustment.

BACKGROUND

Risk is the process of modifying payments and benchmarks and allowing payers to estimate future spending. Risk adjustment systems assign patients a risk score based on demographic factors and health status. Demographic factors may include age, gender, dual eligibility for Medicare and Medicaid (a proxy for socioeconomic status or disability), and whether the patient resides in the community or in a health care facility. Patient health status is usually based on the diagnosis codes
submitted on claims in a calendar year. The importance of accurate risk adjustment is increasing as organizations such as Accountable Care Organizations (ACOs) and other APMs bear financial risk for managing a patient population as well as understanding the needs of individual patients and tailoring care delivery to each patient.

Despite the rising importance of risk adjustment, there are fundamental problems with current risk adjustment methodologies. Most risk adjustment systems only predict about 20-30 percent of the variation in services and spending across patients and are designed to predict spending on a large insured patient population, not adjust for differences in patient needs. For example, risk adjustment that significantly weighs factors such as age and gender communicates a limited picture of the patient. Such simplistic design can reinforce inappropriate spending, penalize efforts to reduce overuse, and cause providers to focus spending reduction efforts on the wrong patients. Additionally, the current risk adjustment methodologies do not adequately address treatment and outcome differences related to patient characteristics. They do not consider the complexity of a patient’s disease nor social risk factors that are outside of the physician’s control, such as lack of transportation or food insecurity. Basing risk scores solely on diagnosis, age and gender, for example, can lead to the same scores being assigned to patients who have drastically different needs. Poorly designed risk adjustment likely distorts comparisons of physician spending.

Moreover, most risk adjustment systems use historical information on patient characteristics and not the most current information. Many systems rely on ICD codes via retrospective review of claims data. Basing risk adjustment on prior claims data means that it accounts for the health conditions patients experienced in previous years but not for significant changes in the patient’s health status or permanent conditions. Some risk adjustment methods do not account for a patient’s disease stage, such as cancer or a patient’s functional status, and they often do not account for factors that influence whether a patient is an appropriate candidate for a procedure or treatment. For instance, risk adjustment systems do not distinguish between patients with different cancer stage diagnoses nor do they account for how the patient’s disease affects activities of daily living or whether they have a caregiver at home.

Importantly, most risk adjustment systems do not account for social determinants of health (SDOH). The link between non-medical factors and poor health outcomes is well documented; however, non-medical factors largely are absent from risk adjustment methods. To enhance fairness in performance assessment, some hospitals have implemented peer group methodology aimed at creating groups of similar hospitals for comparison purposes to account for hospitals that treat a significant number of patients with SDOH challenges. However, peer group comparisons do not take place at a more micro level, and risk adjustment methods are not sophisticated enough to reliably differentiate between poor quality of care and high medical and social risk. These methodological flaws have the unfortunate effect of inappropriately penalizing physicians who care for patients with SDOH challenges. Ultimately, not accounting for SDOH can make it harder for physicians caring for vulnerable patients to maintain a sustainable practice and therefore can reduce access to care for these populations exacerbating the challenge of getting vulnerable populations the care they need.

VARIOUS RISK ADJUSTMENT STRATEGIES

Risk Stratification

Risk stratification is the process of segmenting patients into groups of similar complexity and care needs. The first step in risk stratification is to identify high-risk patients. After stratifying patients into groups, practices can more easily make targeted care management decisions and identify those
patients that may have particular care needs. Consequently, the usefulness of stratification models relies on data availability, which should encompass the patient’s own assessment of his or her health including SDOH. To date, most risk stratification models use a diagnosis-based formula and do not include many SDOH that materially affect patient’s health and ability to follow a particular treatment plan.

One popular method of risk stratification is Medicare Advantage’s (MA) Hierarchical Condition Categories (HCC). Both MA plans and Medicare Shared Savings Program (MSSP) ACOs use the HCC methodology, which relies on ICD-10 coding to assign risk scores derived from retrospective claims data review. The algorithm takes into account demographic factors like age and gender, and insurance companies use HCC coding to assign patients a risk adjustment factor (RAF). In turn, insurers then use the RAF score to help portray patients’ conditions and predict future costs.

Outlier Payments or Individual Stop Loss Insurance

Outlier payments are additional payments paid for by insurers to physicians or organizations to account for encounters and patients that are exceptionally costly. Outlier payments function as a form of stop-loss insurance. Stop-loss insurance protects the provider against significantly higher than intended patient costs. This strategy is particularly useful when available for providers who care for vulnerable populations. Because many SDOH are not yet included in risk stratification systems and overall risk adjustment systems, the ability to access outlier payments after caring for individuals with known high costs is critical for practice financial viability. The strategy also ensures access to care and appropriate treatment for high-risk populations.

Risk Corridors or Aggregate Stop Loss Insurance

Risk corridors are another mechanism that can protect against adverse selection and insufficient physician payments. Risk corridors function by limiting losses and gains beyond an allowable range. Risk corridors set a target spending amount, and insurers pay into the program to compensate those physicians with patient costs exceeding the target. Risk corridors mirror aggregate stop loss insurance in that physicians are protected against higher than expected total spending.

Payment Adjustment for External Price Changes

Adjustment for external price changes is an important protection for physicians operating in a value-based payment delivery system. Under this mechanism, the physician payment is adjusted for changes in the prices of drugs or services from other providers that are beyond the control of the provider accepting the APM payment. Physicians must only be responsible for the services that they deliver and cannot be held financially or otherwise accountable for spending outside of their control. Payment adjustments protect physicians from spending costs outside of their control.

AMA POLICY

AMA policy promotes physician-led payment reform programs that serve as models for others working to improve patient care and lower costs (Policy D-385.963). Policy H-390.844 emphasizes the importance of physician leadership and accountability to deliver high quality and value to patients. The AMA advocates for providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions (Policy H-390.844).
Policy D-390.953 directs the AMA to advocate with the Centers for Medicare & Medicaid Services (CMS) and Congress for APMs developed with specialty and state medical societies. With respect to risk adjustment, Policy H-165.842 states that health insurance coverage of high-risk individuals should be subsidized through mechanisms such as risk adjustment. Policy H-395.908 states that the AMA will work with CMS and interested organizations to design systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient’s health and success of treatment, such as disease stage and SDOH factors. It also calls to account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services. Policy H-395.908 further calls for the AMA to explore an approach in which physicians managing patient care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification. Policy H-390.849 calls for adequate risk adjustment methodologies and encourages attribution processes that emphasize voluntary agreements between patients and physicians. The policy also states that reformed payment rates must be sufficient to maintain a sustainable medical practice and that payment reform implementation should be undertaken within a reasonable timeframe and with adequate assistance.

AMA ACTIVITY

Risk adjustment and risk stratification for APMs have been important components of AMA advocacy on ACOs and other APMs. The AMA has long called for Medicare to allow ACO patients’ risk scores to increase over time if their health care needs warrant, and the 2018 Pathways to Success ACO regulation finally permits such an increase for the first time since the program’s inception. The AMA also has discussed new approaches to risk stratification and risk adjustment in physician-focused APMs at its APM workshops. AMA comments to the Physician-focused Payment Model Technical Advisory Committee and the Center for Medicare and Medicaid Innovation on proposed APMs have repeatedly urged improved approaches to risk adjustment and urged Medicare to provide organizations developing APM proposals with claims and other data analyses that they can use to improve their risk adjustment methods. The AMA also is advocating for improvements to the risk adjustment methodologies in MIPS. For instance, the AMA supports and is engaged in developing episode-based cost measures which account for Medicare Parts A and B spending around a clinically cohesive set of medical services rendered to treat a given medical condition. With AMA input, CMS has developed risk adjustment methods for the episodes that account for patient characteristics that can influence spending outside of the control of the clinician. These measures were first introduced in 2019, and more evidence and testing are needed to determine the accuracy and validity of these measures and their methodologies. In addition, the AMA has advocated for the elimination of the flawed total cost of care measure, which holds physicians accountable for costs outside of their control. The AMA continues to support the complex patient bonus in MIPS, which applies at the final score to adjust for patient complexity. The complex patient bonus is based on the physician’s attributed beneficiaries’ average HCC risk score and the proportion of dually eligible patients. This serves as a proxy to capture the clinical complexity of the patient panels for a physician or practice. However, this approach does not sufficiently identify patients with social risk factors that can affect a patient’s access to medications, treatments, and other services. While adjustment based on the clinical complexity of the patients served through the complex patient bonus is a step toward addressing disparities, CMS must continue to explore and incorporate additional risk factors and strategies.
Additionally, the AMA’s Integrated Health Model Initiative (IHMI) has developed a data model related to the common data elements and terminologies for communicating SDOH. The AMA is collaborating with the largest SDOH standards project in the health information technology community, known as the Gravity Project hosted by the Social Interventions Research and Evaluation Network at the University of California – San Francisco (SIREN).10 IHMI and UnitedHealth Group (UHG) plan to jointly develop a set of use cases that leverage this common data set and publish this use case via the Gravity project. Once the data are standardized and there are sufficient data in the form of patient outcomes related to the standardized SDOH, data driven predictive risk analyses can be formulated. At this point, SDOH risk calculation can be achieved and is based on published research and limited and non-standardized data sets. The goal is to ensure the industry-backed and accepted SDOH data set is complete and suitable for clinician decision making to improve patient outcomes. Moreover, IHMI is working on the creation of new ICD-10 codes related to SDOH such as access to nutritious food and the financial ability to pay for medications.

DISCUSSION

Adverse selection of high-risk patients is an impediment to equitable patient care and successful payment reform. Evidence confirms that factors such as functional impairment and socioeconomic status are strongly associated with increased costs and hospital readmissions, and the exclusion of such factors from risk adjustment systems negatively affects the financial viability of physicians and organizations serving high-risk individuals. Thus, poorly designed risk adjustment systems are a harm to vulnerable populations who may experience decreased access to care.11 The Council reiterates that this report is about risk adjustment, not the assumption of risk. However, it recognizes that the two concepts are linked in that physicians must have better risk adjustment methods available if they are to be expected to access risk arrangements.12 The Council believes that proper risk adjustment is essential if providers are to be held accountable for outcomes.

Throughout the transition to value-based care, the AMA has been vocal that physician accountability must be limited to aspects of spending and quality that they can reasonably influence. Accordingly, the Council recommends supporting payment adjustment for external price changes that are beyond the physician’s control and supporting accountability measures that exclude services that the physician does not deliver, or order, or otherwise have the ability to influence. The AMA also continues to advocate for reduced administrative burden, particularly that related to electronic health records, and the Council reaffirms this commitment.

Additionally, a payment formula that relies solely on medical problems but ignores social risk and functional status can have the effect of underpaying those who care for vulnerable populations and exacerbate health disparities.13 Clinical coding must be coupled with risk adjustment systems, and the two concepts must work in concert to find ways to distinguish between disease states and functional status. Meaningful risk adjustment must allow for variance within existing general diagnoses to capture characteristics specific to individual patients. To that end, the Council recommends supporting risk stratification that varies payment rates based on patient characteristics, including SDOH. Further, the Council recommends supporting outlier payments that increase payment if spending on an individual exceeds a pre-defined threshold or supporting individual stop-loss insurance paid by insurers. Similarly, the Council recommends supporting risk corridors that increase payment if spending on all patients exceeds a pre-defined percentage above the payments or supporting aggregate stop loss insurance. If physicians received extra payments for caring for high-risk and vulnerable populations, these payments could help not only sustain physician practices but also fund services that improve health equity.
Improving risk adjustment and its functions will become increasingly relevant to the viability of practices and the overall health care system. Thorough and accurate risk adjustment not only helps physicians garner the appropriate payment to support practice sustainability, but also helps physicians become more successful in managing their patients. The Council believes that the goal of proper risk adjustment and delivery system reform is tailored interventions and better patient outcomes, and it believes that its recommendations are a step in the right direction. The Council will continue to monitor the rapidly evolving area of risk adjustment methodologies.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-385.908 stating that the AMA will work with the Centers for Medicare & Medicaid Services and interested organizations to design systems that identify data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient’s health and success of treatment, such as disease stage and socio-demographic factors; account for differences in patient needs, such as functional limitations, changes in medical conditions, and ability to access health care services; and explore an approach in which the physician managing a patient’s care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-478.995 advocating for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records so that capturing patient characteristics and risk adjustment measures do not add to physician and practice administrative burden. (Reaffirm HOD Policy)

3. That our AMA support risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications. (New HOD Policy)

4. That our AMA support risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer’s cost. (New HOD Policy)

5. That our AMA support risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer’s cost. (New HOD Policy)

6. That our AMA support risk adjustment systems that use fair and accurate payments for external price changes beyond the physician’s control. (New HOD Policy)

7. That our AMA support accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES

2 Id.
3 Id.
10 The Gravity Project. A National Collaborative to Advance Interoperable Social Risk and Protective Factors Documentation. Available at: https://sirenetwork.ucsf.edu/TheGravityProject
12 Supra note 6.
13 Supra note 4.
Whereas, Medicaid is a state/federal program that pays for healthcare services for low-income pregnant women and adults with and without children, children, individuals who are elderly or have a disability, parents and women with breast or cervical cancer, and

Whereas, Some low-income individuals eligible for Medicaid may qualify for private health insurance funded by Medicaid; and

Whereas, Spending on Medicaid is about one-tenth of the federal budget, $630 million in 2018; and

Whereas, The average annual growth in Medicaid spending is 5.5 percent, exceeding that of private health insurance; and

Whereas, Medicaid member obligations do not always encourage use of the most appropriate care and avenues of care; and

Whereas, Medicaid reimbursement does not always support the most effective and efficient interaction between clinicians and patients; and

Whereas, Some Medicaid policies regarding enrollment qualification and leaving the program encourage patients to behave in ways that are not in the patients’ best interest (e.g., Medicaid spend-down); and

Whereas, Physician-directed oversight of access, quality, and cost can greatly improve Medicaid; and

Whereas, Unnecessary and burdensome administrative requirements on clinicians could be evaluated and reduced; therefore be it
RESOLVED, That our American Medical Association support the following principles of Medicaid reform:

1. Provide appropriate access to care that is the most cost effective and efficient to our citizens.
2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible.
3. Create the best coverage at the lowest possible cost.
4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services.
5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care.
6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care.
7. Assure appropriate payment and positive incentives to encourage but not require clinician participation in Medicaid for both face-to-face and non-face-to-face encounters, under appropriate establishment of clinician-patient relationship.
8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours.
9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health.
10. Eliminate current disincentives (e.g., Medicaid spend-down in order to qualify) to patients improving their lives while on Medicaid, to increase successful transition into the private insurance market.
11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid.
12. Develop a physician directed clinician oversight board at the state level to insure the proper access, quality and cost of care under the Medicaid program throughout all geographically diverse areas of the states.
13. Allow clinicians to see patients for more than one procedure in a visit so that patients do not have to return for another service at an extra cost to the Medicaid program and extra time and effort to the Medicaid patient (e.g., if patient comes because they are sick, allow them to have a diabetes check-up at the same time).
14. Strategically plan to reduce administrative costs and burdens to clinicians, and of the Medicaid program itself, by reducing at least, but not limited to, burdensome documentation requirements, administrative obstacles, and regulatory impediments. (New HOD Policy) and be it further

RESOLVED, That our AMA pursue action to improve the federal requirements for Medicaid programs based on the AMA’s principles of Medicaid reform (Directive to Take Action)

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

Received: 10/03/19
Whereas, Hospital medical staff play a critical role in the function and operations of hospitals and in the relationship that physicians have with hospitals; and

Whereas, The core responsibilities of the organized medical staff are the promotion of patient safety and quality of care; and

Whereas, Members of the organized medical staff may choose to act as a group for the purpose of communicating and dealing with the governing board and others with respect to matters that concern the interest of the organized medical staff and its members; and

Whereas, Individual physician involvement in the political process is important to the good of the nation and for wise decision-making regarding healthcare matters; and

Whereas, Hospital medical staff in a nonprofit setting could endanger the nonprofit status through political actions; and

Whereas, The hospital medical staff leadership should be focused on high quality medical care delivery and not be politicized; therefore be it

RESOLVED, That our American Medical Association support and advocate that hospital medical staff leadership should be fully licensed physicians and that if others are included, they should be non-voting or advisory to the hospital medical staff members (Directive to Take Action); and be it further

RESOLVED, That our AMA support and advocate that the decisions made by hospital medical staffs focus on quality patient care, medical staff standards and the operation of the hospital, and that those decisions not engage the medical staff in external political matters (e.g., advanced practice clinician scope of practice expansion, etc.) (Directive to Take Action); and be it further

RESOLVED, That AMA Policy H-225.993, “Medical Staff Policy Determination,” be rescinded. (Rescind HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/03/19
RELEVANT AMA POLICY

Medical Staff Policy Determination H-225.993
The AMA believes that only fully licensed physicians on the medical staff should establish overall medical staff standards and policy for quality medical care, where consistent with local, state and federal laws.
Citation: (Res. 115, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15)
Whereas, “Pre-authorization” takes up a significant portion of time; and

Whereas, Prior authorization remains a primarily manual, time-consuming process that often
  delays patient access to indicated therapy or even alters the course of therapy and places
  excessive burden on providers, including nurses and pharmacists, health care practices, and
  hospitals; and

Whereas, Prior authorization disrupts workflow and diverts valuable resources away from direct
  patient care; and

Whereas, Despite estimates varying by type and size of health care practice, one survey found
  that, on average, in United States medical practices, physicians spent three hours per week
  interacting with payers, nurses spent 19.1 hours, clerical staff spent 35.9 hours, and
  lawyers/accountants spent 7.2 hours; and

Whereas, This translates into substantial increase in uncompensated overhead health care
  costs; and

Whereas, A critical consequence is nonpayment if prior authorization is not obtained in advance
  of providing the therapy or service; and

Whereas, There are substantial costs with processing prior authorizations for nonformulary
  drugs on the physician office side of managed care as well as on the insurance side of the
  process; and

Whereas, There is some evidence that prior authorization requirements reduce non drug-related
  costs but little evidence that they have a positive impact on clinical or humanistic outcomes; and

Whereas, It has been found that preauthorization is a measurable burden on physician and staff
  time with the mean annual projected cost per full-time equivalent physician for prior
  authorization activities ranged from $2,161 in one study to $3,430 in another; therefore be it

RESOLVED, That our American Medical Association reaffirm policies H-320.939, “Prior
  Authorization and Utilization Management Reform,” and H-385.951, “Remuneration for
  Physician Services.” (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/03/19
RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans’ prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19;

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA’s Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Citation: (Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14)
REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-19

Subject: Mandatory Reporting of Diseases and Conditions (Resolution 915-I-18)

Presented by: Michael M. Miller, MD, Chair

Referred to: Reference Committee K

Resolution 915-I-18, introduced by the American College of Emergency Physicians and referred by the House of Delegates asks:

That our American Medical Association oppose mandated reporting of entire classes of patients and specific diagnoses unless compelling evidence exists to demonstrate that a serious public health and/or safety risk will be mitigated as a result of such reporting.

METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2009 to August 2019 using the search terms: “mandatory reporting,” “nationally notifiable condition,” “electronic case reporting,” “public health surveillance,” “chronic disease registry,” “mandatory reporting” and “noncommunicable disease.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, applicable professional organizations, and foundations were also reviewed for relevant information.

CURRENT AMA POLICY

The AMA has numerous policies calling for improved public health surveillance (e.g., antibiotic use and resistance, cannabis, Creutzfeldt-Jakob disease, firearm-related injuries and deaths, human immunodeficiency virus, infant mortality, lead poisoning, maternal mortality, new psychoactive substances, radon exposure, tobacco consumption, tuberculosis, vector-borne diseases, zoonotic diseases, etc). These policies do not address mandatory reporting or the burden of reporting on physicians. AMA policy also does not address the work underway to modernize public health surveillance and implement electronic case reporting (eCR) thereby removing the burden on physicians, labs, hospitals, and others required to report for the purposes of public health surveillance.

This report will define public health surveillance, explain the difference between mandatory reporting and nationally notifiable conditions, discuss the history of public health surveillance and its expansion beyond infectious diseases, and explain work underway to implement electronic case reporting (eCR) to both improve surveillance and alleviate the burden of reporting on those required to report. The Council on Science and Public Health recognizes public health surveillance is not without risks for individual participants and can pose ethical dilemmas. However, when conducted ethically, public health surveillance is justified for the common good to promote population health and reduce inequalities. The ethical framework for conducting public health surveillance is outside the scope of this report.

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BACKGROUND

Public health surveillance is the ongoing systematic collection, analysis, interpretation and dissemination of health data for the planning, implementation and evaluation of public health action.\(^2\) Public health surveillance is an essential public health function.\(^3\) Surveillance data can be used to estimate the magnitude of health problems, determine the distribution of illness in a population, depict the natural history of a disease, generate hypotheses, stimulate research, evaluate control measures, monitor changes, and facilitate planning.\(^4\)

Disease surveillance usually begins in the health care setting as public health agencies collect disease information from health care providers, facilities, and clinical laboratories required to report diseases and conditions to public health agencies.\(^5\) In the United States, the authority to require notification of cases of diseases resides with the jurisdiction’s state legislature.\(^6\) As a result, the list of diseases and conditions that are reported varies by state.\(^6\) In addition, the time frames for reporting, agencies receiving reports, persons required to report, and conditions under which reports are required also differ.\(^6\) Traditionally, disease reports were made manually or by telephone, mail, or fax.\(^5\) Reporters have indicated that manual submission of disease reports is time-consuming and disruptive to workflow.\(^5\)

The Nationally Notifiable Disease List differs from mandatory reporting in that notifiable diseases are reported to the Centers for Disease Control and Prevention (CDC) on a voluntary basis by each jurisdiction. The Council of State and Territorial Epidemiologists works with the CDC to determine which conditions reported to local, state, and territorial public health departments are nationally notifiable.\(^8\)

This Council on Science and Public Health report stems from the enactment of legislation in California in 2017 that requires the State Department of Public Health to collect data on the incidence of Parkinson’s disease in California.\(^8\) The legislation also requires a hospital, facility, physician and surgeon, or other health care provider diagnosing or providing treatment to Parkinson’s disease patients to report each case of Parkinson’s disease to the department, beginning July 1, 2018.\(^8\)

DISCUSSION

Historically, surveillance focused on infectious diseases, it then broadened to other topics, including chronic diseases (e.g., cancer and diabetes), occupational health, environmental health, hazard surveillance (toxic chemicals and physical and biological agents), and injury control (e.g., firearm-related injury).\(^9\) It is expected that additional diseases and conditions will be explored in the future.\(^9\) As state legislatures consider adding to their jurisdiction’s list of diseases and conditions that are required to be reported to public health agencies, they should consult with state and national medical societies and public health agencies to ensure the requirements are based on scientific evidence and will meet the needs of population health.

Chronic Disease Surveillance

Chronic diseases are conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States and the leading drivers of health care costs.\(^10\) The rise in chronic disease burden led to the development of chronic disease surveillance systems. In the 1970s, morbidity from select chronic diseases came under surveillance through disease registries.\(^11\) In the 1980s and 1990s, CDC and state health agencies
collaboratively developed additional surveillance systems to monitor behavioral risk factors for chronic disease. This led to the use of the Behavioral Risk Factor Surveillance System and the Youth Risk Behavioral Surveillance System to monitor health risk behaviors. In 1992, Congress authorized the National Program of Cancer Registries at CDC to monitor local trends in cancer incidence and mortality with statewide, population-based cancer registries. The benefits of public health surveillance on these conditions include determining incidence and survival rates, evaluating treatment efficacy, targeting educational and screening programs, and conducting research on etiology, diagnosis and treatment.

Neurological Conditions Surveillance

In 2016, as part of the 21st Century Cures Act, Congress authorized CDC to initiate development of a National Neurological Conditions Surveillance System to begin collecting and analyzing data on neurological disorders. The CDC will begin by exploring and synthesizing data from existing sources to gain an increased understanding of multiple sclerosis and Parkinson’s disease. Once model approaches for surveillance are identified, the NCSS will be extended to other neurological conditions as resources allow.

On the state level, Nebraska was the first jurisdiction to implement a Parkinson’s disease registry. The law requires that physicians and pharmacists report individuals diagnosed with Parkinson's and patients taking anti-Parkinson’s medications to the Nebraska Department of Health and Human Services Regulation and Licensure. In 2015, Utah launched its Parkinson’s Disease Registry to understand the apparent rise in the disease in the state and uncover causes of the disease. Effective March 12, 2015, the Utah State Board of Health began requiring health care providers to report cases of Parkinson’s Disease and related movement disorders. California was the third state to require reporting of Parkinson’s Disease. Since July of 2018, 122,727 records have been submitted to the California Parkinson’s Disease Registry. These data will be used to: (1) determine the incidence and prevalence of Parkinson’s disease in California; (2) examine disparities in Parkinson’s disease risk; and (3) conduct demographic and epidemiological research and other studies of Parkinson’s disease. These provisions under the California law are set to expire in 2020, but legislation is currently being considered to extend the registry and reporting requirements beyond 2020.

The Digital Bridge, funded by the Robert Wood Johnson Foundation and the de Beaumont Foundation, provides a forum for key decision-makers in health care, public health and health information technology (IT) committed to promoting bidirectional, or two-way, information exchange between the health care and public health sectors. The Digital Bridge promotes the use of national health IT infrastructure to alleviate the administrative burden and costs of outdated, siloed data exchange practices. Goals for the Digital Bridge include: (1) easing the burden and costs for all stakeholder groups through a unified approach to information exchange; (2) advancing greater standards-based information exchange across public health and health care; and (3) laying the foundation for greater bidirectional exchange of data so that clinicians can be more informed about population health, environmental risks and outbreaks. The AMA is currently a member of the Governance Body for the Digital Bridge. Electronic case reporting (eCR) was the first use case for the Digital Bridge.
Electronic Case Reporting (eCR)

With more than 80 percent of office-based physicians having adopted electronic health record (EHR) systems, it is not surprising the future of public health surveillance is eCR, a process by which reportable conditions are automatically generated from EHR systems to public health agencies for review and action, in accordance with applicable health care privacy and public health reporting laws17 (see Figure). The advancement of eCR could lead to more accurate and timely case data for public health action resulting in improved detection of outbreaks, earlier identification of disease risk factors, and a decreased burden on mandatory reporters, including physicians.17

The electronic initial case report (eICR) would be identified in the EHR through a standard set of trigger codes that flag when a provider diagnoses a reportable condition based on International Classification of Diseases, Tenth Revision codes for diagnoses, LOINC (Logical Observation Identifiers Names and Codes) for laboratory testing orders, or SNOMED CT (Systematized Nomenclature of Medicine–Clinical Terms) for clinical information and laboratory results.16 The Association of Public Health Laboratories, Council of State and Territorial Epidemiologists, and CDC have already vetted the reportable trigger codes for 5 conditions (e.g., gonorrhea, chlamydia, salmonella, pertussis, and Zika virus infections) and are in the process of identifying codes for all reportable conditions.17

After potential cases are identified through trigger codes, the eICR will automatically be generated with case information.17 The eICR will contain a minimum set of data elements that have been established to be used for all conditions in all jurisdictions. The eICR will be transmitted from the EHR to an intermediary platform via secure, broadly used data transport mechanisms.16 On these platforms, a software application will assess the reportability of the disease or condition via a logic model based on the jurisdiction’s mandated reporting requirements and then will route adjudicated cases to the appropriate agencies.17

The Reportable Conditions Knowledge Management System (RCKMS) is a software application that will unpack, transform, and adjudicate the eICR automatically in a secure environment to determine whether the potential case meets minimal criteria consistent with mandated reporting based on a standard logic specific to jurisdictional requirements. RCKMS will transmit reportable cases to jurisdictions for final classification and action.17 Health care providers will be informed when cases have been reported.16 CDC has supported the Health Level 7 Consolidated Clinical Document Architecture as the initial structure for transmitting the eICR, based on standards that are already in use.

Houston was the first pilot site under the Digital Bridge initiative to successfully launch eCR. Partners involved in the Houston demonstration include Houston Health Department, Houston Methodist, and Epic Systems.18 California, Kansas, Massachusetts, Michigan, New York, and Utah have also been selected as pilot sites.19 The CDC recently identified Parkinson’s disease for inclusion as a test case for the Digital Bridge. The Digital Bridge and CDC have committed to working with the California Department of Public Health to implement eCR across California health systems to collect data on Parkinson’s disease cases seen by health care providers in a burden-free manner.

CONCLUSION

Public health surveillance is an essential public health function and coordination between health care and public health agencies is essential for the monitoring, control, and prevention of disease. The AMA has numerous policies calling for improved public health surveillance on a wide range
of topics. A policy opposing mandatory reporting for specific conditions due to the burden it places on physicians could jeopardize our understanding of disease occurrence and severity (e.g., cancer), as well as new causes, risk factors, and early identification of disease clusters. In addition to increases in disease incidence, reporting can also demonstrate the decline in disease among the population and help with the evaluation of prevention programs (e.g., vaccines).

To ensure that new diseases reporting requirements are based on the scientific evidence and will meet the needs of population health, the AMA encourages state legislatures to engage state and national medical specialty societies and public health agencies when proposing mandatory disease reporting requirements. The AMA should also support the modernization of public health surveillance systems and recognize the benefits of eCR in both improving public health surveillance through more accurate and timely data and alleviating the reporting burden on physicians.

RECOMMENDATIONS

The Council recommends that the following recommendation for new policy be adopted in lieu of Resolution 915-I-18, and the remainder of the report be filed.

Public Health Surveillance

That our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal funding to modernize our nation’s public health data systems to improve the quality and timeliness of data; (5) supports electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting.

(New HOD Policy)

Fiscal Note: less than $1,000.
Figure

Source: The Digital Bridge
REFERENCES

8. California Senate Bill 97
Whereas, Medical care facilities include hospitals, skilled nursing facilities, intermediate care facilities, and correctional treatment facilities such as prisons; and

Whereas, Current AMA policy H-150.949 encourages healthy, plant-based options to be provided within hospitals, but does not explicitly encourage the same of other medical care facilities; and

Whereas, There is a lack of consistency in food safety and option regulations among prisons at the local and state level; and

Whereas, Centers for Medicare & Medicaid Services regulations require nursing facilities to provide a “nourishing, palatable, well-balanced diet that meets ... daily nutritional and special dietary needs”, but does not explicitly address plant-based diets; and

Whereas, A study found 65% of nursing home residents expressed complaints about their food service and the presence of complaints was related to poor food intake; and

Whereas, Plant-based diets have been shown to improve health in all people, not just hospitalized patients; and

Whereas, Plant-based options also have the potential to be cheaper than alternatives depending on the decisions made by individual facilities regarding costs for purchase, storage and preparation; therefore be it

RESOLVED, That our American Medical Association encourage the availability of healthy, plant-based options at medical care facilities by amending AMA Policy H-150.949, “Healthy Food Options in Hospitals,” by addition and deletion to read as follows:

**Healthy Food Options in Hospitals Medical Care Facilities, H-150.949**

1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on the premises of Medical Care Facilities.

2. Our AMA hereby calls on US hospitals all Medical Care Facilities and Correctional Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.

3. Our AMA hereby calls for hospital Medical Care Facility cafeterias and inpatient meal menus to publish nutrition information. (Modify Current HOD Policy)
Fiscal Note: Minimal - less than $1,000

Received: 08/28/19

References:

RELEVANT AMA POLICY:

Dietary Intake of Incarcerated Populations D-430.995
Our AMA: 1) urges the National Commission on Correctional Health Care, the American Correctional Association, and individual states to mandate adherence to the current Dietary Reference Intakes and Dietary Guidelines for Americans (with adjustments, as needed, for special populations) as a criterion for accreditation and/or standards compliance, until national dietary guidelines specific for adolescent and adult incarcerated populations becomes available; and 2) urges the Food and Nutrition Board of the Institute of Medicine to examine the nutrient status and dietary requirements of incarcerated populations and issue guidelines on menu planning for adolescent and adult incarcerated populations.
Citation: (CSAPH Rep. 4, A-11)

Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants H-150.945
Our AMA:
1. supports federal, state, and local policies to require fast-food and other chain restaurants with 10 or more units (smaller, neighborhood restaurants could be exempt) to provide consumers with nutrition information on menus and menu boards;
2. recommends that nutrition information in fast-food and other chain restaurants include calorie, fat, saturated fat and trans fat, and sodium labeling on printed menus, and, at a minimum,
calories on menu boards, since they have limited space, and that all nutrition information be conspicuous and easily legible;
3. urges federal, state, and local health agencies, health organizations, and physicians and other health professionals to educate people how to use the nutrition information provided in restaurants to make healthier food choices for themselves and their families; and
4. urges restaurants to improve the nutritional quality of their menu offerings—for example, by reducing caloric content; offering smaller portions; offering more fruits, vegetables, and whole-grain items; using less sodium; using cooking fats lower in saturated and trans fats; and using less added sugars/sweeteners.
Citation: Res. 419, A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09; Reaffirmed: CSAPH Rep. 01, A-19

H-150.944 Increasing Healthy Food Options in School Lunches for Elementary and Middle School Students
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.
Citation: Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

H-150.949 Health Food Options in Hospitals
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises.
2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.
3. Our AMA hereby calls for hospital cafeterias and inpatient meal menus to publish nutrition information.
Citation: Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17; Modified: Res. 425, A-18
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912
(I-19)

Introduced by: Young Physicians Section

Subject: Improved Emergency Response Planning for Infectious Disease Outbreaks

Referred to: Reference Committee K

Whereas, In the Blueprint list of priority diseases released by the World Health Organization in February 2018, a “Disease X”, or an unexpected infectious disease, was added representing an unknown pathogen with a serious international epidemic potential; and

Whereas, The Centers for Disease Control and Prevention has faced budget cuts of 1.525 billion dollars over the last three fiscal years; and

Whereas, Continued public health funding is fundamental to maintaining essential services to the general population in prevention, outbreak investigation, and emergency response; and

Whereas, Availability of funding for an unexpected infectious disease prior to its clinical presentation would allow for patterned syndromic surveillance; and

Whereas, Early identification of a potential infectious disease outbreak reduces transmission, morbidity, mortality; and

Whereas, Early identification and public health messaging provides education for the general public; therefore be it

RESOLVED, That our American Medical Association encourage hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery (Directive to Take Action); and be it further

RESOLVED, That our AMA support flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage health departments to develop public health messaging to provide education on unexpected infectious disease. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 09/26/19
RELEVANT AMA POLICY

Federal Block Grants and Public Health H-440.912
(1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.
(2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.
(3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.
(4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.
(5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.
6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.

Citation: CSA Rep. 3, A-96; Reaffirmation A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed in lieu of Res. 424, A-11; Appended: Res. 935, I-11; Reaffirmation A-15; Reaffirmed in lieu of: Res. 419, A-19;

Pandemic Preparedness for Influenza H-440.847
In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such
agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

Citation: (CSAPH Rep. 5, I-12; Reaffirmation A-15)

Next Generation Infectious Diseases Diagnostics H-440.834
1. Our American Medical Association supports strong federal efforts to stimulate early research and development of emerging rapid ID (infectious disease) diagnostic technologies through increased funding for appropriate agencies.
2. Our AMA supports the reduction of regulatory barriers to allow for safe and effective emerging rapid diagnostic tests, particularly those that address unmet medical needs, to more rapidly reach laboratories for use in patient care.
3. Our AMA supports improving the clinical integration of new diagnostic technologies into patient care through outcomes research that demonstrates the impact of diagnostics on patient care and outcomes, educational programs and clinical practice guidelines for health care providers on the appropriate use of diagnostics, and integration of diagnostic tests results into electronic medical records.
4. Our AMA supports efforts to overcome reimbursement barriers to ensure coverage of the cost of emerging diagnostics.

Citation: (Res. 507, A-15; Reaffirmed: CSAPH Rep. 3, I-15)

Public and Private Funding of Prevention Research D-425.999
Our AMA seeks to work in partnership with the Centers for Disease Control and Prevention, the National Institutes of Health, and other Federal Agencies, the Public Health Community, and the managed care community to ensure that there is a national prevention research agenda.

Citation: Res. 418, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18;

AMA Leadership in the Medical Response to Terrorism and Other Disasters H-130.946
Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters.
(2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts.
(3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post traumatic stress disorders associated with exposure to disaster, tragedy, and trauma.
(4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the
role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional's role in these systems.

(5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level.

(6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues.

(7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters.

(8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.

Citation: (BOT Rep. 26, I-01; Reaffirmed: BOT Rep. 3, I-02; Modified: CSA Rep. 1, I-03; Reaffirmed: CME Rep. 1, I-11; Reaffirmation A-15)

**Fund for Public Health Emergency Response H-440.825**

Our AMA supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.

Citation: Res. 420, A-16;

**Global Tracking System of Zoonotic Diseases D-440.940**

Our AMA will work with the American Veterinary Medical Association and other relevant stakeholders to encourage the US Departments of Health and Human Services, Agriculture, Interior, and other appropriate federal and state agencies to take the lead in establishing a robust, coordinated, and effective global surveillance system of zoonotic diseases in humans and syndromic outbreaks in animals, thereby enhancing collaboration of human and animal health sectors and resulting in improved early detection and response.

Citation: Sub. Res. 519, A-10; Reaffirmed: CSAPH Rep. 04, A-19;

**References:**

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-19

Subject: Amendment to E-1.2.2, “Disruptive Behavior by Patients”

Presented by: Kathryn L. Moseley, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Policy D-65.991, “Discrimination against Physicians by Patients,” directs the American Medical Association (AMA) to study “(1) the prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients’ requests; (2) hospitals’ and other health care systems’ policies or procedures for handling patient bias; and (3) the legal, ethical, and practical implications of accommodating or refusing such reassignment requests.”

The following analysis by the Council on Ethical and Judicial Affairs (CEJA) examines ethics concerns in this area and offers guidance for physicians when they encounter patients who refuse or demand care based on the physician’s perceived personal, rather than professional, characteristics.

REASONS MATTER: DISTINGUISHING PREFERENCE FROM PREJUDICE

It is not known just how often patients discriminate against or sexually harass physicians (and other health care personnel) as data are not systematically collected or publicly reported. However, a growing number of studies and an expanding body of anecdotal reports suggest that such behavior is pervasive in health U.S. care [e.g., 1–7]. In the words of one analyst discrimination by patients is medicine’s “open secret” [4].

A survey conducted jointly by Medscape and WebMD in 2017 found that 59% of respondents overall heard an offensive remark from a patient about the physician’s personal characteristic, including comments about the physician’s weight and political views in addition to comments about age, ethnicity or national origin, gender, race, and sexual orientation [8]. Emergency physicians were significantly more likely to report having experienced bias (83%) than primary care physicians (62%) or specialists (59%). Among respondents, more African American (70%), Asian (69%), and Hispanic (63%) physicians reported hearing biased comments compared to white physicians (55%). The same survey found that male and female physicians experience bias differently, notably in terms of the physician characteristics targeted. For example, female respondents reported experiencing bias more often on the basis of their gender or age than male physicians (41% versus 6% and 36% versus 23%, respectively), while male physicians experienced bias based on their ethnicity or religion somewhat more often than their female colleagues (24% versus 20% and 15% versus 8%, respectively).

*Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.
A variety of factors can drive patient behavior that is disrespectful, derogatory, or prejudiced, including mental illness or incapacity or individual life experience, as well as personal beliefs and bias. Different drivers carry different implications for whether, or to what degree, patients can reasonably be held responsible for their problematic behavior. It would not be appropriate to hold patients responsible or blameworthy for statements or actions that are not the product of rational thought in the moment [9]. Thus, physicians’ first response to problematic behavior should to explore the reasons underlying the behavior so that they can identify, appreciate, and address potentially treatable conditions. Behavior that outright threatens the safety of health care personnel or other patients calls for prompt action to de-escalate the situation or remove the threat [e.g., 10, 11].

Lingering systemic racism and health disparities in the United States shape the experience of both patients and health care professionals, especially those from nondominant communities [1, 3, 12]. Against this background, patients’ reasons for refusing care by a specific physician or requesting a different physician cover a “spectrum of justifiability” [13].

Requests not to be treated by a specific physician may reflect fears or concerns about care that are rooted in systemic discrimination against members of the patient’s community or traumatic experiences in a patient’s personal history [4, 9, 13]. Requests for a physician concordant in ethnicity, religion, or gender may reflect cultural preferences or traditions, for example, a Muslim woman’s preference to receive care from a female physician. Such requests may also reflect patients’ experience, or reasonable expectation, that they will be better understood by a physician “like them.” Evidence suggests that at least for some patients, racial/ethnic or cultural concordance between patient and physician supports more effective communication, enhances satisfaction, and may have clinical benefit [4]. In these situations, it is appropriate to respect patient concerns and preferences, when doing so is clinically feasible.

Requests for an alternative physician based solely on prejudice against personal characteristics of the physician, however, are not justifiable and need not—perhaps should not—be accommodated [4, 9, 13]. Requests based on a physician’s (actual or perceived) race/ethnicity, national origin, creed, gender identity, sexual orientation, disability, or other personal characteristic are ethically objectionable.

For physicians and health care institutions faced with patients’ strongly held views about who should provide care, then, a central task is distinguishing when a patient’s stated preference rests on ethically acceptable reasons and when it reflects unacceptable bias or prejudice. When, that is, will accommodation serve important patient interests and when will it reinforce problematic stereotypes and, in effect if not intent, condone bigotry [2, 9]?

PROTECTING INTERESTS, MINIMIZING HARMs

Patient refusals of care or demands for alternative caregivers challenge physicians, and the institutions in which they work, to protect both the interests of patients and those of physicians. In such situations, physicians’ professional obligations to promote patient well-being, respect patients as moral agents and autonomous decision makers, and fulfill the duty to treat without discrimination come into tension in potentially novel ways. Nor do these responsibilities align with physicians’ own interests in upholding professional autonomy and themselves being free from discrimination. There are potential harms to both parties whether the physician/institution accommodates bigoted requests and removes the caregiver or requires patient and physician to engage one another in a troubled relationship.
Physicians’ fiduciary obligations are fundamental. Physicians are expected to promote patients’ interest and well-being without regard to individuals’ personal characteristics or behavior, up to and including providing care to individuals whose behavior may be morally repugnant [13, 14]. But whether continuing to provide care or allowing oneself to be withdrawn from a case better fulfills that fiduciary obligation is only intelligible in the individual case. So too are interpretations of how a physician is to respect the autonomy of a patient who asserts moral agency in the form of prejudice, and what the duty to care entails when the recipient behaves in a way that, arguably, is not morally worthy or acceptable. Reaching sound determinations in these matters cannot be done by rote; instead, as one commentator observed, doing so calls for “nuanced ethical judgment” [13].

The American Medical Association Code of Medical Ethics enjoins physicians to provide “competent medical care, with compassion and respect for human dignity and rights” [15]. It also acknowledges that, except in emergencies, physicians shall be “free to choose whom to serve” [16].

The Code further delineates the conditions under which a physician may decline to accept a new patient (or provide a specific service to an existing patient [17]. These include when the care requested is outside the physician’s competence or scope of practice; when the physician lacks the resources to provide safe, competent, respectful care for the individual; and when meeting this patient’s medically needs seriously compromises the physician’s ability to provide the care needed by other patients. Importantly, guidance acknowledges that, except in emergencies, a physician may decline to provide care when the patient “is abusive or threatens the physician, staff, or other patients” [17]. At the same time, the Code provides that physicians may terminate a relationship with a patient who “uses derogatory language or acts in a prejudicial manner only if the patient will not modify the behavior,” in which case the physician should arrange to transfer the patient’s care [emphasis added] [18].

One approach to determining the ethically appropriate response to prejudiced behavior by patients is to explore the harms—to patients, to physicians and other health care professionals, and to health care institutions and even the wider community—that can result from different possible responses. Who, that is, is harmed by a given response, and in what way?

Thwarting the requests of seemingly bigoted patients for alternative caregivers exposes patients to possible delays in care and poorer health outcomes, should they choose to leave the facility (with or without assistance from the institution). If they do not, or cannot leave, patients are subjected to the experience of receiving medical care from a physician against whom they are biased. Distinguishing between a preference for a different physician and a demand for one is important in thinking about the nature and degree of harm the patient may experience. A preference is “an expression of an inclination that may be gratified or not”; a demand is “more of an ultimatum, in which failure to meet its indicia may be met not only with disappointment but also anger and resentment” [9]. Further, it is important to determine why the patient is making the request/demand, which may have a clinical source, such as delirium, dementia, or psychosis [4, 13], that is outside the patient’s control, as opposed to being a stance the patient has voluntarily adopted. And as noted previously, requests/demands may also reflect life experiences that color a patient’s response to caregivers for which accommodation may be appropriate.

For physicians and other caregivers, acceding to bigoted demands can send powerful, but unintended and potentially hurtful messages—that minority or female physicians are “not as good” as white male physicians or that patient satisfaction scores are more important to the institution than promoting a safe and ethical working environment [1, 19]. Accommodating bigotry can make institutions complicit in discrimination [19], in the process tacitly condoning or reinforcing an
institutional culture that routinely subjects minority physicians to “barrages of microaggressions and biases” or expects them to serve as “race/ethnicity ambassadors” [1].

Institutions that fail to support staff in the face of prejudice convey that complying with patient demands “is more important than respecting the dignity of both their staff members and the majority of patients, who do not hold such repugnant views (or at least do not openly act on them)” [9]. Institutions, some argue, “have a duty to present a moral face to their community by refusing to honor bigoted or prejudicial requests or demands as a matter of course, up to and including declining to care for such patients (except in emergency situations)” [9, cp. 20].

Regardless of how their institutions respond, for many minority health care professionals, interactions with prejudiced patients are painful and degrading and contributed to moral distress and burnout [4]. Requiring physicians to provide care when a patient has openly expressed bias is not ethically tenable. As one physician described his own experience of ultimately declining to work with a particular patient, “After years of feeling that my race was a nonissue, I was subjected to the same kind of hurtful name-calling that I faced in childhood. Even as self-loathing for not having thicker skin began to creep in, I decided that, on this occasion, my feelings would count” [21]. Absent unique situations, institutions should allow physicians to control the decision about whether they will continue to provide care [19]. Some have argued that institutions have a responsibility to monitor such encounters and their effects on an ongoing basis “with the goal of supporting staff and improving the handling of these situations” [4].

Whether patient prejudice against physicians adversely affects quality of care has not been well studied. One experimental study among family practice physicians in the Netherlands concluded that “disruptive behaviours displayed by patients seem to induce doctors to make diagnostic errors” [22]. A companion study attributed this to the fact that the “mental resources” devoted to dealing with patient behavior interfered with “adequate processing of clinical findings” [23]. Evidence does indicate that physician “burnout” can adversely affect patient outcomes [e.g., 24–26]. To the extent that being the target of patient prejudice contributes to the emotional exhaustion, sense of depersonalization, and sense of low personal accomplishment characteristic of burnout, it is reasonable to expect biased behavior to be associated with lower quality of care, particularly if targeted physicians feel they do not have the support of their colleagues or institutions when bias occurs [1, 21, 27, 28].

**LAW AND POLICY**

Legally, at the federal level how a health care institution responds to prejudiced behavior by patients falls within the scope of the *Emergency Medical Treatment and Active Labor Act* (EMTALA) and by anti-discrimination law in Title VII of the *Civil Rights Act of 1965* (CRA). When patients make requests based on the physician’s race, hospitals are in the position of having to meet EMTALA requirements while respecting physicians’ employment rights [4]. Hospitals can “inform patients of their right to seek care elsewhere and their responsibility to refrain from hateful speech,” but their ability “to remove physicians in response to race-based requests is circumscribed” [4]. Although physicians have not sued under CRA [4], in a case that ultimately settled, an African-American nurse in Michigan sued her employer when she was barred from caring for a white baby at the request of the child’s father, a white supremacist [29].

At present, relatively few institutions have formal policy or procedures for dealing with incidents of patient prejudice, although an increasing number broadly enjoin patients to behave in a respectful manner under policies delineating patient rights and responsibilities and indicate that misconduct will not be tolerated [e.g., 30, 31]. Two notable exceptions are Toronto’s University
Health Network (UHN) and Mayo Clinic, both of which explicitly seek to balance the interests of patients and health care personnel.

UHN’s Caregiver Preference Guidelines focus on three key questions: whether the preference for an alternative caregiver appears to discriminate against the health care professional on the basis of race, ancestry or other characteristic as provided in the Ontario Human Rights Code; whether the request is clinically feasible and/or indicated to a reasonable degree; and whether the caregiver wishes to excuse themselves from caring for the patient [27]. Mayo’s recently adopted policy directs staff to step in when they observe behavior that is not in keeping with Mayo Clinic values; address the behavior with the patient, focusing the conversation on Mayo’s published values; explain the institution’s expectations and set boundaries with the individual; and report the incident to supervisors and document it via a patient misconduct form [27].

RECOMMENDATION

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, “Discrimination against Physicians by Patients,” be rescinded; Opinion 1.2.2, “Disruptive Behavior by Patients,” be amended by addition and deletion as follows; and the remainder of this report be filed:

The relationship between patients and physicians is based on trust and should serve to promote patients’ well-being while respecting the dignity and rights of both patients and physicians.

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

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

(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those they target who are targeted.

(b) Always treat patients with compassion and respect.

(c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient’s behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.

(d) In general, decline to accommodate patient requests for an alternative physician when the request is solely the product of prejudice against the physician’s personal characteristics.

(e) Consider accommodating a patient’s request for an alternative physician when the request derives from the patient’s adverse personal experience, doing so would promote effective care, and another appropriately qualified physician is available to provide the needed care.
(f) In emergency situations, patients who persist in opposing treatment from the physician
assigned may be helped to seek care from other sources. When transfer is not feasible,
patients should be informed that care will be provided by appropriately qualified staff
independent of the patient’s expressed preference.

(eg) Terminate the patient-physician relationship with a patient who uses derogatory language
or acts in a prejudiced manner whose volitional behavior is disrespectful, derogatory, or
prejudiced only if the patient will not modify the conduct. In such cases, the physician
should arrange to transfer the patient’s care when that is feasible.

Physicians, especially those in leadership roles, should encourage the institutions with which
they are affiliated to:

(h) Be mindful of the messages the institution conveys within and outside its walls by how it
responds to prejudiced behavior by patients.

(i) Promote a safe and respectful working environment and formally set clear expectations for
how disrespectful, derogatory, or prejudiced behavior by patients will be managed.

(j) Clearly and openly support physicians, trainees, and facility personnel who experience
prejudiced behavior and discrimination by patients.

(k) Collect data regarding incidents of discrimination by patients and their effects on
physicians and facility personnel on an ongoing basis and seek to improve how incidents
are addressed to better meet the needs of patients, physicians, other facility personnel, and
the community.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500
REFERENCES


Subject: Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals (Resolution 414-A-19)

Presented by: Michael M. Miller, MD, Chair

Referred to: Reference Committee K

Resolution 414-A-19, introduced by the Oklahoma Delegation and referred by the House of Delegates asks:

That our American Medical Association offer guidance to medical staffs regarding patient use of non-US Food and Drug Administration approved medical marijuana and cannabinoids on hospital property, including product use, storage in patient rooms, nursing areas and/or pharmacy, with report back to the House of Delegates at the 2019 Interim Meeting.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases from January 2009 to August 2019 using the search terms: “hospital policies” and cannabis; “hospital policies” and marijuana. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional organizations, including hospital associations, were reviewed for relevant information.

The Council on Science and Public Health acknowledges that the use of non-FDA approved cannabis and cannabinoid products presents challenges in health care facilities beyond hospitals (e.g., long-term care facilities, mental health and addiction facilities) and patients (e.g., visitors and employees), but those issues were deemed outside of the scope of this report.

CURRENT AMA POLICY

The AMA believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use. Furthermore, cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process. The AMA also supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws and believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions (D-95.969, “Cannabis Legalization for Medicinal Use”).

The AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-
based medical cannabis programs, the legalization of cannabis, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product (H-95.952, “Cannabis and Cannabinoid Research”).

STATUS OF CANNABIS UNDER FEDERAL LAW

Under the U.S. Controlled Substances Act (CSA) of 1970, cannabis is classified as a Schedule I controlled substance, meaning it has no currently accepted medical use in treatment in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse. This means that the cultivation, manufacture, sale distribution, and use of medical cannabis violates the CSA and constitutes a federal felony.

Cannabis is not FDA-approved as a safe and effective drug for any indication. However, the agency has approved three drug products containing synthetic versions of the main psychoactive ingredient of cannabis, delta-9 tetrahydrocannabinol (THC). Marinol® and Syndros™, which include the active ingredient dronabinol, are indicated for nausea and vomiting associated with cancer chemotherapy and anorexia associated with weight loss in patients with AIDS. Cesamet®, which contains the active ingredient nabilone, is also indicated for the treatment of the nausea and vomiting associated with cancer chemotherapy.

The Agriculture Improvement Act of 2018 (Farm Bill) removed hemp from the CSA, which means cannabis plants and derivatives that contain no more than 0.3 percent THC on a dry weight basis are no longer controlled substances under federal law. However, the law explicitly preserved FDA’s authority to regulate products containing cannabis or cannabis-derived compounds. The FDA has approved one cannabis-derived product, Epidiolex®, which contains a purified form of the drug substance cannabidiol (CBD) for the treatment of seizures associated with Lennox-Gastaut or Dravet syndrome. The FDA has expressed concern at the proliferation of products asserting to contain CBD that are being marketed for therapeutic or medical uses that have not been approved by FDA. Since CBD has been studied as a new drug, it cannot be legally included in foods or dietary supplements. The FDA is currently considering potential regulatory frameworks for CBD.

STATUS OF CANNABIS UNDER STATE LAW

At the state level, trends in law have moved from decriminalization, to the legalization of medical use of cannabis, to cannabis regulated for adult use. California was the first jurisdiction in the United States to legalize the medical use of cannabis. Today, 33 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands have legalized the medical use of cannabis through either the legislative process or ballot measures. These laws vary greatly by jurisdiction, from how patients access the product (home cultivated or dispensary), to qualifying conditions, product safety and testing requirements, packaging and labeling requirements, and consumption method (some states prohibit smoking the product). In jurisdictions that have legalized cannabis for medicinal use, physicians can “certify” or “recommend” a qualifying patient for the medicinal use of cannabis, but physicians cannot prescribe cannabis for medical purposes because it is illegal under federal law. In recent years, an additional 17 states have enacted laws allowing access to low THC/high CBD products for children with epilepsy.

In 2012, Colorado and Washington were the first U.S. jurisdictions to legalize the adult use of cannabis for recreational purposes. Today, a total of 11 states and the District of Columbia have legalized cannabis for adult use. Most of these jurisdictions have created for-profit, commercial cannabis production and distribution markets where the product is sold and taxed.
DISCUSSION

The AMA does not approve of state-based medical cannabis programs, the legalization of cannabis, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. Hospitals are being encouraged to accommodate patient use of cannabis. The primary argument for allowing patients to use cannabis in hospitals is focused on continuity of care. If patients have had success using cannabis for medicinal purposes, ending that treatment due to a hospital admission disrupts treatment and could lead to worse outcomes.

Risks to Hospitals in Allowing Patient Use of Cannabis Products

Hospitals are subject to federal law because they receive reimbursement from federal programs. Since cannabis is a Schedule 1 controlled substance, its manufacture, distribution, or possession is a criminal offense. Hospitals that allow patient use of cannabis are at risk of violating federal law, losing their deemed status from Centers for Medicare and Medicaid Services (CMS), exposing themselves to possible penalties or sanctions, and losing federal funding. Physicians who maintain DEA licensure are also subject to federal law and are not permitted to prescribe a Schedule I substance. In addition to the prohibition on prescribing, the DEA also prohibits a practitioner from administering a Schedule I substance, which means that physicians and other clinicians with DEA licenses cannot administer cannabis. Doing so may jeopardize a clinician’s federal DEA registration and their ability to prescribe controlled substances.

In addition to federal law, hospitals must also meet standards for pharmacies and medication management such as those established by hospital accreditation bodies. For example, The Joint Commission Standard MM.03.01.05 on Medication Management requires that: “[t]he hospital safely controls medications brought into the hospital by patients, their families, or licensed independent practitioners.” This standard includes the following elements of performance:

- The hospital defines when medications brought into the hospital by patients, their families, or licensed independent practitioners can be administered.
- Before use or administration of a medication brought into the hospital by a patient, his or her family, or a licensed independent practitioner, the hospital identifies the medication and visually evaluates the medication's integrity.
- The hospital informs the prescriber and patient if the medication brought into the hospital by patients, their families, or licensed independent practitioners is not permitted.

One of the biggest challenges for hospitals in meeting this standard for cannabis would likely be identifying the medication and visually evaluating the medication’s integrity. Depending on state law, the patient may be enrolled in the state’s cannabis for “medicinal use” program and have their own supply from a state licensed manufacturer. However, the hospital would likely not want to assume responsibility for vetting the substance or any adverse effects the patient experiences as a result of the product.

Hospitals would also have to address medication storage concerns, particularly if cannabis products should be stored with the pharmacy department and treated as a controlled substance, by security personnel, or with the patient. There are also complicated logistics for self-administration of cannabis by the patient or caregiver. Many hospitals have policies on self-administration of
medicines that permit patients to use their own medications only after identification and labeling by pharmacy personnel.

Since many hospitals have policies prohibiting smoking on facility grounds, hospitals would have to determine what preparations of cannabis would be allowed (e.g., oils or edibles). Hospitals should also be prepared to provide information to their medical staffs on cannabis withdrawal symptoms as well as possible cannabis or cannabinoid contraindications, drug interactions, or possible adverse effects.

**State Laws Addressing Cannabis Use in Hospitals**

Some states have tried to address cannabis use in hospital facilities by amending their state laws. Connecticut and Maine permit the use of cannabis by hospitalized patients and give some state-level legal protection for clinicians who administer it. Connecticut law provides that a nurse shall not be subject to arrest or prosecution, or penalized in any manner for administering cannabis to a qualifying patient or research program subject in a hospital or health care facility licensed by the Department of Public Health.

Maine has enacted protection for hospitals and long-term care facilities for use of edible cannabis products, tinctures, and salves by an admitted patient who has been certified for use of cannabis products under state law. The law provides that hospitals and long-term care facilities are not subject to prosecution, search, seizure or penalty in any manner, including but not limited to a civil penalty or disciplinary action by an occupational or professional licensing board or entity, and may not be denied any license, registration, right or privilege solely because the admitted patient lawfully engages in conduct involving the medical use of cannabis. These protections also apply to officers or directors, employees or agents of a hospital or long-term care facility.

Minnesota law provides that hospitals may adopt reasonable restrictions on use and storage of cannabis. The restrictions may include a provision that the provider will not store or maintain the patient's supply of cannabis, that the provider is not responsible for providing cannabis for patients, and that cannabis be used only in a place specified by the provider. Under Minnesota state law, employees of these facilities are not subject to violations under the statutes for possession while carrying out employment duties, such as providing or supervising care to a registered patient, or distribution of cannabis to a registered patient.

The Minnesota Hospital Association (MHA) convened a broad group of stakeholders to discuss the impact of the state’s cannabis law on hospital workflows as well as policies and procedures. The group produced template polices on cannabis for MHA members. The policies can be summarized as follows: (1) the hospital will not allow patient use of cannabis, (2) the hospital will allow inpatients to continue use while inpatient in the hospital and cannabis will be treated as self-administered home therapy, and (3) the hospital will allow inpatients to continue while inpatient in the hospital and cannabis will be treated as a medication and integrated within the hospital medical workflows.

**CONCLUSION**

It is the AMA’s position that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use. The AMA does not believe cannabis for medicinal use should be legalized through the state legislative, ballot initiative, or referendum process. Given the growing number of states that have legalized cannabis use, hospitals
are increasingly likely to encounter patients who are taking cannabis or cannabis-related products. It has been argued that patients should be allowed to use non-FDA approved cannabis-related products to ensure continuity of care if they are admitted to the hospital. However, hospitals and physicians face legal risks in doing so given cannabis’ status as a Schedule I controlled substance. Hospitals should consider the risks associated with allowing the use of non-FDA approved cannabis or cannabis-derived products by patients and develop policies to address this issue so patients and clinicians have clarity on what is permitted. Hospitals that decide to allow the use of non-FDA approved cannabis or cannabis-derived products should provide information to their medical staffs on cannabis withdrawal symptoms as well as possible cannabis or cannabinoid contraindications, drug interactions, or possible adverse effects.

RECOMMENDATIONS

The Council recommends that the following recommendation be adopted in lieu of Resolution 414-A-19, and the remainder of the report be filed.

The AMA encourages hospitals and health systems to: (1) engage stakeholders, including, but not limited to physicians, nurses, pharmacists, legal counsel, experts in controlled substance diversion prevention, as well as relevant state and federal agencies in developing policies for addressing patient use of non-FDA approved cannabis or cannabis-derived products for use within their facilities and (2) communicate their policy on patient use of non-FDA approved cannabis or cannabis-derived products within their facilities, to ensure clinicians are prepared to treat patients in accordance with policy. (New HOD Policy)

Fiscal Note: less than $500
REFERENCES

1. 21 USC 812.
9. Joint Commission Standard MM.03.01.05.
10. Joint Commission Standard MM.03.01.01.
14. Minn. Stat. Sec. 152.34.
Whereas, Substance Use Disorder (SUD) affects over 20.2 million people in America and have been shown to cause detrimental effects on mental and physical health\(^1\); and

Whereas, The Centers for Disease Control and Prevention declared the opioid epidemic a public health crisis, with over 200,000 deaths resulting from the epidemic in 2018\(^2\); and

Whereas, There are minimal standards for outpatient addiction rehabilitation facilities on a state and national level, which is uncharacteristic in other outpatient settings\(^3\); and

Whereas, There is a lack of evidence-based practices within outpatient addiction rehabilitation centers despite solid evidence of the efficacy of alternative treatments\(^4,5\); and

Whereas, The fraudulent activity of outpatient addiction rehabilitation centers is a problem that faces many states across the country and has led to federal prosecutions in California and Florida\(^6,7\); and

Whereas, The lack of regulation of outpatient addiction rehabilitation centers has led to facilities promoting unconventional and non-evidence-based therapies as effective and proven methods for treating SUDs\(^3,8\); and

Whereas, The lack of regulation of outpatient addiction rehabilitation centers and their affiliates has led to the exploitation of patients and their insurance for monetary gain in the form of disbursements for sober homes who send patients to the respective facilities\(^6,7,9\); and

Whereas, The success of patients maintaining sobriety and improved social outcomes is largely dependent on continuing outpatient care following initial treatment\(^10\); and

Whereas, Meta-analysis and systematic review suggest that addiction rehabilitation can be made substantially more efficacious by increasing availability of simultaneous psychosocial and medication-based interventions\(^11,12\); and

Whereas, Providing medication assisted treatment for SUDs after an inpatient stay or detoxification stay may help prevent future readmissions\(^13\); therefore be it
RESOLVED, That our American Medical Association advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 08/28/19

References:
1. Lipari RN and Van Horn SL. Trends in substance use disorders among adults aged 18 or older. The CBHSQ Report. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD. Published 29 June 2017.

RELEVANT AMA POLICY

Substance Use and Substance Use Disorders H-95.922
Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders; (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Citation: CSAPH Rep. 01, A-18;
Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

1. Our AMA:
   a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
   b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
   c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;
   d. will consult with relevant agencies on potential strategies to actively involve physicians in being a part of the solution to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
   e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.

2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:
   a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;
   b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and
   c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

Citation: (CSAPH Rep. 2, I-08; Appended: Res. 517, A-15; Reaffirmed: BOT Rep. 5, I-15)

Medicaid Substance Use Disorder Coverage H-290.962

1. Our AMA will advocate that the Centers for Medicare and Medicaid Services provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders.
2. Our AMA will advocate for clear billing and coding processes regarding the medical management and treatment of all substance use disorders.
3. Our AMA recognizes the expertise of addiction specialist physicians and the importance of improving access to management and treatment of addiction services with Medicaid payment for all physician specialties.

Citation: Res. 125, A-17;

Modernizing Privacy Regulations for Addiction Treatment Records H-315.965

Our AMA supports: (1) regulatory and legislative changes that better balance patients’ privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders; (2) regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders; and (3) continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system.

Citation: Res. 224, I-17

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.
Substance Use Disorders During Pregnancy H-420.950
Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual’s family structure, (b) the patient’s treatment status, and (c) current impairment status when substance use is suspected.

Survey of Addiction Treatment Centers’ Availability H-95.926
Our AMA: (1) encourages the Substance Abuse and Mental Health Services Administration (SAMHSA) to use its national surveys to increase the information available on the type of insurance (e.g., Medicaid, Medicare, private insurance) accepted by substance use disorder treatment programs listed in SAMHSA’s treatment locators; (2) encourages physicians who are authorized to provide medication assisted treatment to opt in to be listed publicly in SAMHSA’s treatment locators; and (3) encourages SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities.

Role of Self-Help in Addiction Treatment H-95.951
The AMA: (1) recognizes that (a) patients in need of treatment for alcohol or other substance use disorders should be treated for these medical conditions by qualified professionals in a manner consonant with accepted practice guidelines and patient placement criteria; and (b) self-help groups are valuable resources for many patients and their families and should be utilized by physicians as adjuncts to a treatment plan; and (2) urges managed care organizations and insurers to consider self-help as a complement to, not a substitute for, treatment directed by professionals, and to refrain from using their patient's involvement in self-help activities as a basis for denying authorization for payment for professional treatment of patients and their families who need such care.

Federal Drug Policy in the United States H-95.981
The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.

Perinatal Addiction - Issues in Care and Prevention H-420.962
Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and
breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

Citation: (BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13)

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.
2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages.
4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.
5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.

Citation: Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18; Reaffirmation: A-19;

Community-Based Treatment Centers H-160.963
Our AMA supports the use of community-based treatment centers for substance abuse, emotional disorders and developmental disabilities.

Citation: (BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)
Whereas, The Centers for Medicare and Medicaid Services (CMS), through the Promoting Interoperability Program for hospitals and MIPS eligible clinicians, currently requires health care providers to share patient health data (including laboratory and pathology data) through an application programming interface (API) within four days of its availability; and

Whereas, CMS recently issued an Advanced Notice of Proposed Rulemaking (ANPRM) that seeks comment on whether Merit-based Incentive Payment System (MIPS) eligible clinicians should be required to make patient health information available immediately through an API no later than one day after it is available to the clinicians in the certified electronic health record technology (CEHRT); and

Whereas, This, if implemented, would be part of the Quality Payment Program’s (QPP) Promoting Interoperability (PI) performance category and therefore directly impacts MIPS participants and their reimbursement; and

Whereas, Generally, feasibility of information exchange is driven by improvements in technology and the health information technology (HIT) infrastructure is led by vendors and developers, not physicians; and

Whereas, EHR prompts do not give physicians the ability to publish notes into just the practice-facing chart then separately into the patient-facing portal; and

Whereas, Patient access to their protected health information (PHI) should be supported, there are concerns relating to immediate availability of certain laboratory and pathology test results because patients would have access to pathology reports prior to a consultation with their physician to aid in the understanding of the results; and

Whereas, This situation could cause significant patient and family distress so it is important to equip patients with the necessary contextual information and clinical expertise provided by their physicians when reviewing test results; therefore be it

RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services to create guardrails around the “immediate” availability of laboratory, pathology, and radiology results, factoring in an allowance for physician judgement and discretion regarding the timing of release of certain results (Directive to Take Action); and be it further
RESOLVED, That our AMA encourage vendors to implement prompts that give physicians the ability to either approve notes to just the chart or approve and publish them in both the chart and patient portal. (Directive to Take Action)

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

Received: 10/17/19

RELEVANT AMA POLICY

Information Technology Standards and Costs D-478.996
1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

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

Citation: Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19
Resolution: 804
(I-19)

Introduced by: Indiana

Subject: Protecting Seniors from Medicare Advantage Plans

Referred to: Reference Committee J

Whereas, Medicare Advantage plans are heavily marketed to seniors by insurance companies, with less than ideal transparency in advertising; and

Whereas, These plans produce higher insurance company profits at cost to CMS because Advantage plans are paid at a higher rate than traditional Medicare; and

Whereas, There also is the potential for higher annual and lifetime costs for the patient under an Advantage Plan; and

Whereas, Presentations by insurance company officials to seniors can overemphasize the value of different options and can create confusion; therefore be it

RESOLVED, That our American Medical Association encourage AARP, insurance companies and other vested parties to develop simplified tools and guidelines for comparing and contrasting Medicare Advantage plans. (New HOD Policy)

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

Received: 09/27/19

RELEVANT AMA POLICY

Whereas, AMA Policy D-95.969, “Cannabis Legalization for Medicinal Use,” states, in part, that our AMA: “(2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process;” and

Whereas, AMA Policy H-95.924, “Cannabis Legalization for Recreational Use,” states, in part, that our AMA: “(5) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis use;” and

Whereas, AMA Policy H-95.923, “Taxes on Cannabis Products,” states that “our AMA encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including: substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts;” and

Whereas, AMA Policy H-95.952, “Cannabis and Cannabinoid Research,” states, in part, that our AMA: “(4) supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding; and (5) urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic and social consequences of its use;” and

Whereas, Despite existing AMA policies, “ten states and the District of Columbia have full legalization [of recreational cannabis], and another 23 states permit medicinal uses with permission from a doctor, according to the National Conference of State Legislatures;”¹ and

Whereas, Legalization of both hemp and cannabis have bipartisan support in Congress;² and

Whereas, Emerging research in Colorado has shown that “marijuana use during pregnancy, concerns related to marijuana in homes with children, and adolescent use should continue to guide public health education and prevention efforts:

- The percentage of women who use marijuana in pregnancy…is higher among younger women, women with less education, and women with unintended pregnancies.
- Marijuana exposure in pregnancy is associated with decreased cognitive function and attention problems in childhood.
- Unintentional marijuana consumption among children under age 9 continues a slow upward trend, as do emergency visits due to marijuana. Additionally, an estimated 23,000 homes with children in Colorado have marijuana stored potentially unsafely.
Marijuana exposures in children can lead to significant clinical effects that require medical attention;” and

Whereas, Dr. Tista Ghosh of the Colorado Department of Public Health and Environment states that “it’s critical we continue to monitor use in all populations and work to minimize harms that could result from a variety of causes including unintended poisoning, unsafe driving, and mental health issues that may be associated with long-term, habitual use;” and

Whereas, In Washington State, where recreational marijuana use was decriminalized, “between 2011 and 2013, there was an average of 155 marijuana-related calls per year to the Poison Control Center; from 2014 to 2016 the average number of calls was 268, a 73% increase;” and

Whereas, the Rocky Mountain High Intensity Drug Trafficking Area has been tracking the impact of marijuana legalization in the state of Colorado, finding that:

− “Marijuana-related traffic deaths increased 48% in the three-year average (2013-2015) since Colorado legalized recreational marijuana compared to the three-year average (2010-2012) prior to legalization;
  o During the same time, all traffic deaths increased 11%;
− Marijuana-related traffic deaths increased 62% from 71 to 115 persons after recreational marijuana was legalized in 2013;
− In 2009, Colorado marijuana-related traffic deaths involving operators testing positive for marijuana represented 10% of all traffic fatalities. By 2015, that number doubled to 21%;
− Emergency department rates likely related to marijuana increased 49% in the two-year average (2013-2014) since Colorado legalized recreational marijuana compared to the two-year average prior to legalization (2011-2012);
− Hospital[ization] rates likely related to marijuana increased 32% in the three-year average (2013-2015) since Colorado legalized recreational marijuana compared to the three-year average prior to legalization (2010-2012);
− Of the 394 seizures in 2015, there were 36 different states destined to receive marijuana from Colorado. The most common destinations identified were Missouri, Illinois, Texas, Iowa, and Florida;” and

Whereas, States sharing a border with states that have legalized recreational marijuana may have increased public health and public safety impacts, with no potential benefits from the tax revenues associated with that legalization; and

Whereas, The AMA Council on Science and Public Health Report 5-I-17, “Clinical Implications and Policy Consideration of Cannabis Use,” states that “ongoing surveillance to determine the impact of cannabis legalization and commercialization on public health and safety will be critical. Surveillance should include but not be limited to the impact on patterns of use, traffic fatalities and injuries, emergency department visits and hospitalizations, unintentional exposures, exposure to second-hand smoke, and cannabis-related treatment admissions. At-risk populations, including pregnant women and children, should be a focus of attention. Continued evaluation of the effectiveness of regulations developed to ensure public health and safety in states that have legalized the medical and/or recreational use of cannabis is necessary;” therefore be it

RESOLVED, That our American Medical Association work with interested organizations to collate existing worldwide data on the public health impacts, societal impacts, and unintended consequences of legalization and/or decriminalization of cannabis for recreational and medicinal use, with a report back at the 2020 Interim Meeting (Directive to Take Action); and be it further
RESOLVED, That our AMA continue to encourage research on the unintended consequences of legalization and decriminalization of cannabis for recreational and medicinal use in an effort to promote public health and public safety (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage dissemination of information on the public health impacts of legalization and decriminalization of cannabis for recreational and medicinal use, with consideration of making links to that information available on the AMA website (Directive to Take Action); and be it further

RESOLVED, That our AMA work with interested organizations to lobby Congress to allow more sites to conduct research on the risks and benefits of cannabinoid products. (Directive to Take Action)

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

Received: 09/26/19

RELEVANT AMA POLICY

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936
Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed.
Citation: Res. 922, I-15; Reaffirmed: CSAPH Rep. 05, I-17;

Taxes on Cannabis Products H-95.923
Our AMA encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including: substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts.
Citation: CSAPH Rep. 05, I-17;

Cannabis and Cannabinoid Research H-95.952
1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana’s status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
Cannabis Legalization for Recreational Use H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for recreational use should not be legalized; (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (3) believes states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis use; and (6) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use.
Citation: CSAPH Rep. 05, I-17;

Cannabis Legalization for Medicinal Use D-95.969
Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medicinal use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; and (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 211, A-18;

References:
## Schedule of education sessions

**You Thought You Only Had A Duty of Care to Your Patients? – Minnesota’s Warren v. Dinter decision**  
Thursday, November 14, 1:30 – 2:00 p.m., Marina G, Marriott Marquis  
Presenter: Leonard Nelson, Esq.

**Peer Review Survival Kit – Is your Peer Review Process Safe?**  
Friday, November 15, 9:15 – 10:15 a.m., Marina G, Marriott Marquis  
Presenter: Elizabeth Snelson, Esq.

**The AMA Policymaking Lifecycle: Turning Ideas into Policy and Then into Solutions!**  
Friday, November 15, 12:30 – 1:15 p.m., Marina G, Marriott Marquis  
Presenter: Matthew Gold, M.D.

**Credentialing, Privileging and Enrollment Processes: How What You Don’t Know Can Hurt You!**  
Friday, November 15, 1:30 – 2:30 p.m., Marina G, Marriott Marquis  
Presenters: Tammy Weaver & Susan Diaz, CPCS, CPMSM

**Demystifying Employment Contracts**  
Friday, November 15, 2:45 – 3:45 p.m., Marina G, Marriott Marquis;  
Repeated, Saturday, November 16, 9:30 – 10:30 a.m., Harbor Ballroom G-H,  
Manchester Grand Hyatt  
Presenter: Richard Levenstein, Esq.

## Speaker biographies

## Speaker slides

*For the best user experience, please download a copy of this handbook to your personal device*
You thought you only had a duty of care to your patients? –

Minnesota's Warren v. Dinter decision

2019 AMA Interim Meeting

1:30 p.m.– 2 p.m. | Thursday, November 14 | Marina G Marriott Marquis | San Diego, California | .5 AMA PRA Category 1 Credits

Program Description

The Minnesota Supreme Court's recent decision in the case of Warren v. Dinter could substantially expand a physician's liability for negligent care by holding that a physician-patient relationship need not be formally established before the physician, acting in his/her professional capacity, has a duty of care to that patient. In this activity, our speaker will review Dinter and then discuss the ramifications of the decision on physicians' medical practices.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

Deadline for claiming CME credit is December 31, 2019. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of .5 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Peer Review Survival Kit:
Is Your Peer Review Process Safe?

2019 AMA Interim Meeting

9:15 a.m.–10:15 a.m. | Friday, November 15 | Marina G Marriott Marquis | San Diego, California | 1.0 AMA PRA Category 1 Credits

Program Description

The medical profession is held in the highest esteem by the public. A key for this high regard is the seriousness with which the Profession approaches patient safety and quality of care. While the institutional peer review process plays a big part in maintaining and enhancing patient safety and quality, few physicians have intricate knowledge of the process or can identify issues that will define an effective and fair process. This activity is designed to educate physicians and physicians in training so that at the conclusion of the activity, learners will understand the process, be able to distinguish between an effective and fair process and one that is not so, and the Process’ importance to the medical profession.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

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The AMA designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
AMA Policymaking Life Cycle - Turning Ideas Into Policy and Then Into Solutions!

2019 AMA Interim Meeting

12:30 p.m.– 1:15 p.m. | Friday, November 15 | Marina G Marriott Marquis | San Diego, California | .75 AMA PRA Category 1 Credits

Program Description

All too often, an AMA member will have a great idea or a solution to a vexing problem in his/her practice and not know how to move it forward. This session will inform attendees about AMA's existing policy formulation tools and then provide guidance on how to turn an idea or solution into implementable policy. Importantly, our speaker will discuss strategies for successfully moving resolutions through the policy making process, as well as share case studies of successful and unsuccessful scenarios. This session will also provide plenty of time for discussion, interaction and questions and is designed to be a very practical workshop for learners who are interested in developing AMA policy.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

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The AMA designates this live activity for a maximum of .75 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
The Credentialing, Privileging and Enrollment Processes:

How what you don't know can hurt you!

2019 AMA Interim Meeting

1:30 p.m. – 2:30 p.m. | Friday, November 15 | Marina G Marriott Marquis | San Diego, California | 1.0 AMA PRA Category 1 Credits

Program Description

Physicians and physicians in training work hard and with great commitment to their patients and to their profession. The credentialing, privileging and enrollment processes enable them to work at hospitals and similarly situated health care facilities, as well as enable them to receive payment for their services. Therefore, successfully navigating these processes is critical to being their professional well-being. Rejection could be devastating to a medical career as a denial is reportable to bodies such as the National Practitioner Data Bank. This activity is designed to ensure that at the conclusion of the activity, learners have a comprehensive understanding of the credentialing, privileging and enrollment processes, as well as being sensitized to current and future trends and challenges in all three processes.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

Deadline for claiming CME credit is December 31, 2019. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The AMA designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Demystifying Employment Contracts

2019 AMA Interim Meeting

2:45 p.m. – 3:45 p.m. | Friday, November 15 | Marina G Marriott Marquis | San Diego, California | 1.0 AMA PRA Category 1 Credits

Program Description

The employment contract is a critical document for the physician when he/she decides to enter into employment with a health care facility or medical group. Yet, too often, the physician fails to thoroughly read a proposed contract and/or understand the importance of the document. This activity is designed to educate and to sensitize the learner about the importance of an employment contract and the key provisions that should be contained in such a document.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

Deadline for claiming CME credit is December 31, 2019. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.