

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(I-19)

Introduced by: American Orthopaedic Foot and Ankle Society

Subject: State Board Scope of Practice Expansion Beyond Statute

Referred to: Reference Committee B (_____, Chair)

1 Whereas, The limits of health care provider scope of practice are determined by legislative
2 statute; and
3

4 Whereas, State boards have the authority to enforce statutory scope of practice but not the
5 authority to expand it beyond legislative intent; and
6

7 Whereas, The Ohio Revised Code contains all of the laws that have been passed by the
8 legislature and the Ohio Administrative Code contains all of the rules passed by the various
9 state agencies; and
10

11 Whereas, Ohio Revised Code Section 4731.51 states:
12

13 The practice of podiatric medicine and surgery consists of the medical, mechanical,
14 and surgical treatment of ailments of the foot, the muscles and tendons of the leg
15 governing the functions of the foot; and superficial lesions of the hand other than
16 those associated with trauma. Podiatrists are permitted the use of such
17 preparations, medicines, and drugs as may be necessary for the treatment of such
18 ailments. A podiatrist may treat the local manifestations of systemic diseases as
19 they appear in the hand and foot, but the patient shall be concurrently referred to a
20 doctor of medicine or a doctor of osteopathic medicine and surgery for the
21 treatment of the systemic disease itself;¹ and
22

23 Whereas, In 1997 the State Medical Board of Ohio (SMBO) created Ohio Administrative Code,
24 Rule 4731-20-01, which states:
25

26 "Foot," as used in section of the Revised Code, means the terminal appendage of
27 the lower extremity and includes the ankle joint which consists of the tibial plafond,
28 its posterolateral border (posterior malleolus), the medial malleolus, distal fibula
29 (lateral malleolus) and the talus;² and
30

31 Whereas, In 1997 the SMBO created Ohio Administrative Code, Rule 4731-20-02, which allows
32 a "podiatric physician" to perform surgery on the ankle joint when they meet specific
33 requirements;³ and
34

35 Whereas, Anatomy textbooks do not include the tibia and fibula in the definition of the foot; and

¹ <http://codes.ohio.gov/orc/4731.51>

² <http://codes.ohio.gov/oac/4731-20-01v1>

³ <http://codes.ohio.gov/oac/4731-20-02v1>

1 Whereas, The Connecticut Supreme Court⁴ and the Texas Appellate Court⁵ have ruled against
2 their state's podiatry board's attempt to increase scope of practice by defining "foot" as including
3 the "ankle;" and
4

5 Whereas, On September 12, 2007, the SBMO responded to a letter of inquiry by stating:
6

7 an appropriately trained podiatric physician may perform split thickness skin grafts
8 whereby skin is harvested from the anterior thigh for grafting to an area below the
9 knee when the procedure is medically appropriate for the treatment of foot and
10 ankle pathologies;⁶ and
11

12 Whereas, On September 12, 2007, the SMBO responded to a letter of inquiry by stating:
13

14 an Ohio podiatric physician who has successfully completed appropriate training
15 may perform peroneal nerve decompression for the relief of foot and ankle
16 pathologies, such as diabetic neuropathy, when the procedure is medically
17 appropriate," and noted "the surgical treatment of peroneal nerve compression
18 requires that an incision be made over the neck of the fibula;⁷ and
19

20 Whereas, On June 12, 2019, the SMBO correctly responded to a letter of inquiry by stating:
21

22 harvesting of a bone graft from the proximal tibia to be used for foot and ankle
23 surgery is not within the podiatric scope of practice as defined in the Ohio Revised
24 Code and Administrative Code.
25

26 The SMBO noted:
27

28 The proximal tibia is not within the definition of "foot." In addition, a bone graft
29 requires an incision at the donor site so that bone may be removed at the donor
30 site. This minor surgical procedure at the proximal tibia also does not constitute the
31 use of a preparation, medicine, or drug for the surgical treatment of the foot;⁸ and
32

33 Whereas, On June 12, 2019, the SMBO incorrectly responded to another item in the same letter
34 of inquiry by stating:
35

36 Harvesting bone marrow aspirate from the proximal tibia to be used for foot and
37 ankle surgery is within the scope of practice of an appropriately trained podiatric
38 physician.
39

40 The SMBO noted:
41

42 The harvesting of bone marrow aspirate does not require an incision but is performed
43 by insertion of a needle into the cortex;⁸ and

⁴ *State Medical Society v. Board of Exam. in Podiatry*, 208 Conn. 709, 546 A.2d 830 (Conn. 1988), available at <https://casetext.com/case/state-medical-society-v-board-of-exam-in-podiatry>.

⁵ *Texas Orthopaedic Assn. v. Bd. of Podiatric Medical Examiners*, 254 S.W.3d 714 (Tex. App. 2008), available at <https://caselaw.findlaw.com/tx-court-of-appeals/1307282.html>.

⁶ http://www.ohfama.org/aws/OHFAMA/asset_manager/get_file/94476/split_thickness_skin_graft.pdf

⁷ http://ohfama.org/aws/OHFAMA/asset_manager/get_file/94473/peroneal_nerve.pdf

⁸ http://www.ohfama.org/aws/OHFAMA/asset_manager/get_file/341236/scope-aspirate-nails-supramalleolas-osteo-hand-warts.pdf

1 Whereas, At least one of the reasons the SMBO used to deny harvesting of bone graft
2 from the proximal tibia clearly applies to the harvesting of bone marrow aspirate from
3 the proximal tibia as the proximal tibia is not within the definition of "foot;" and
4

5 Whereas, The article the SMBO referenced with respect to harvesting bone marrow aspirate
6 from the proximal tibia has photographs showing a mallet hitting a trochar through an incision
7 over the proximal tibia, as well as warning to "be keenly aware of the proximity to the knee joint
8 so as to avoid inadvertent violation of the knee;"⁹ and
9

10 Whereas, Unlike bone marrow biopsy, which is within the statutory scope of practice of
11 physician (MDs and DOs as defined by the AMA), often up to 60 cc of bone marrow aspirate is
12 harvested from the proximal tibia and then, with or without concentration or mixture with material
13 such as allograft bone chips, re-implanted into the patient's foot and ankle; and
14

15 Whereas, On June 12, 2019, the SMBO incorrectly responded to another item in the same letter
16 of inquiry by stating:
17

18 a supramalleolar osteotomy of the tibia or fibula constitutes ankle surgery, as
19 defined in Rule 4731-20-02, OAC, and is within the podiatric scope of practice of
20 an appropriately trained podiatric physician;⁸ and
21

22 Whereas, The definition of "supra" is "above" and supramalleolar osteotomies of the fibula and
23 tibia are performed above or proximal to the medial, lateral, and posterior malleoli, areas clearly
24 outside the definition of both "foot" and "ankle" as defined in the Ohio Revised Code and
25 Administrative Code; and
26

27 Whereas, The AMA, the Ohio State Medical Association, the Ohio Orthopaedic Society, the
28 American Orthopaedic Foot & Ankle Society, and the American Academy of Orthopaedic
29 Surgeons submitted letters to the SMBO in opposition to its June 12th letter, on the basis that
30 such findings expanded podiatric scope of practice outside state statute and/or requested that
31 SMBO reconsider its positions; and
32

33 Whereas, In its September 11, 2019 meeting, the SMBO upheld its previous decisions allowing
34 podiatrists in Ohio to harvest bone marrow aspirate from the proximal tibia and perform
35 supramalleolar osteotomies of the tibia and fibula;¹⁰ and
36

37 Whereas, In the September 11, 2019 meeting, the orthopaedic surgeon representative on the
38 SMBO who was unable to attend the June meeting, articulately explained how the SMBO's
39 June 12th responses were both internally inconsistent and incompatible with the plain meaning
40 of the statute governing the practice of podiatry in the State of Ohio; and
41

42 Whereas, The minutes further reflect that the position was predominately based upon (i)
43 hesitation about setting precedent to reconsider promulgated guidance, and (ii) the fact that
44 podiatrists have already been performing these procedures for a significant period of time
45 presumably in the State of Ohio, and a fear of the retroactive implications of an adverse
46 decision in this regard. Instead, the SMBO seemed focused on personal exposure and more
47 specifically, anti-trust exposure, as a result of their June 12th position (or any decision to
48 diverge therefrom); and

⁹ "Bone Marrow Aspirate: Science and Application in Foot and Ankle Surgery," McGlamry, Michael C., DPM,
http://www.podiatryinstitute.com/pdfs/Update_2012/2012_22.pdf

¹⁰ <https://med.ohio.gov/Portals/0/For%20The%20Public/Board%20Meetings%20and%20Minutes/2019/9-2019%20Approved%20SMBO%20Minutes.pdf?ver=2019-10-17-170905-290>, pp. 35-41.

1 Whereas, Confirming certain procedures as within the statutory scope of podiatric practice
2 poses a threat to patient safety, and sets a dangerous legal precedent that once enough
3 practitioners begin practicing outside the scope of their statutory authority, the fear of retribution
4 justifies authorizing the continued practice, notwithstanding its clear violation of the plain
5 meaning of the applicable statute; and
6

7 Whereas, The implications of the precedent of states boards advancing provider scope of
8 practice beyond state statute are applicable not just to podiatrists, but all non-physician health
9 care providers; therefore be it
10

11 RESOLVED, That our American Medical Association consider all available legal, regulatory, and
12 legislative options to correct the State Medical Board of Ohio's erroneous decisions to increase
13 podiatric scope of practice beyond legislative statute with respect to (1) allowing podiatrists in
14 Ohio to harvest bone marrow aspirate from the proximal tibia, and (2) allowing podiatrists in
15 Ohio to perform supramalleolar osteotomies of the tibia and fibula (Directive to Take Action);
16 and be it further
17

18 RESOLVED, That our AMA consider all available legal, regulatory, and legislative options to
19 correct the previous decisions made by the State Medical Board of Ohio to increase podiatric
20 scope of practice beyond legislative statute with respect to defining the foot as including the
21 ankle, allowing split thickness skin grafting from the anterior thigh, and allowing common
22 peroneal nerve decompression at and proximal to the neck of the fibula (Directive to Take
23 Action); and be it further
24

25 RESOLVED, That our AMA consider all available legal, regulatory, and legislative options to
26 oppose state board decisions that increase non-physician health care provider scope of practice
27 beyond legislative statute or regulation. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 – \$5000.

Received: 11/15/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002
(I-19)

Introduced by: Colorado, American Association of Public Health Physicians

Subject: Appropriate Use of Scientific Studies and Data in the Development of Public Policy

Referred to: Reference Committee B _____, Chair)

1 Whereas, The purpose of environmental laws is to protect human, animal, and plant health, and
2 to conserve resources for future needs of people, animals, and plants; and
3

4 Whereas, Broad pursuit of these objectives requires considering all applicable science; and
5

6 Whereas, An “Environmental Protection Agency proposal, titled Strengthening Transparency in
7 Regulatory Science, would require that scientists disclose all of their raw data, including
8 confidential medical records, before the agency could consider an academic study’s
9 conclusions”¹; and
10

11 Whereas, The Strengthening Transparency in Regulatory Science proposal “would make it
12 more difficult to enact new clean air and water rules because many studies detailing the links
13 between pollution and disease rely on personal health information gathered under confidentiality
14 agreements”²; and
15

16 Whereas, In testimony given to the House Committee on Science, Space and Technology,
17 Linda Birnbaum, who retired last month as director of the National Institute of Environmental
18 Health Sciences stated that “It will practically lead to the elimination of science from decision-
19 making” and the “effects here could affect an entire generation”³; and
20

21 Whereas, Scientific studies used to craft policies such as the Clean Air Act and other
22 environmental protections have been developed using longitudinal medical record data which is
23 Protected Health Information (PHI); and
24

25 Whereas, The proposed EPA rule would be retroactively applicable, thus putting much of
26 current environmental protections at risk without release of PHI; and
27

28 Whereas, Our AMA has strong policy on protections for patient privacy⁴; and
29

30 Whereas, Evaluating all available scientific information is central to all aspects of the EPA
31 regulatory process; therefore be it
32

33 RESOLVED, That our American Medical Association actively oppose implementation of
34 proposed changes to 40 CFR Part 30 put forward by the Environmental Protection Agency as
35 reported in draft form on November 11, 2019 and titled “Strengthening Transparency in
36 Regulatory Science” (Directive to Take Action); and be it further

¹ <https://www.nytimes.com/2019/11/11/climate/epa-science-trump.html?searchResultPosition=1>

² *ibid*

³ <https://apnews.com/a08af1be0af54a1c800c2773519d9212>

⁴ Patient Privacy and Confidentiality H-315.983

- 1 RESOLVED, That our AMA support the use of all credible scientific data in the development of
- 2 public policy while recognizing the need to safeguard Protected Health Information. (New HOD
- 3 Policy)

Fiscal Note: Modest – between \$1,000 – \$5000.

Received: 11/15/19

REFERRAL CHANGES AND OTHER REVISIONS (I-19)

WITHDRAWN REPORTS AND RESOLUTIONS

- BOT Report 10 – Childcare at AMA HOD Meetings
- Resolution 218 – Private Payers and Office Visit Policies

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- 213 - Data Completeness and the House of Medicine (Colorado, Idaho, Arizona, Hawaii, Utah)
- 215 - Board Certification of Physician Assistants (American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, 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, Pennsylvania, Michigan)
- 808 - Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs (American Academy of Physical Medicine & Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine, Wisconsin)

* Additional sponsors underlined.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials

Presented by: Cheryl Gibson-Fountain, MD, Chair
Sunday, November 17, 2019

1 Mister Speaker, Members of the House of Delegates:

2 3 (1) LATE RESOLUTION(S)

4
5 The Committee on Rules and Credentials met Saturday, November 16, to discuss Late
6 Resolution(s) 1001 and 1002. Sponsors of the late resolutions met with the committee to
7 consider late resolutions and were given the opportunity to present for the committee's
8 consideration the reason the resolution could not be submitted in a timely fashion and the
9 urgency of consideration by the House of Delegates at this meeting.

10
11 Recommended for acceptance:

- 12
13 • Late 1002 – Appropriate Use of Scientific Studies and Data in the Development of Public
14 Policy

15
16 Recommended not be accepted:

- 17
18 • Late 1001 – State Board Scope of Practice Expansion Beyond Statute

19 20 (2) REAFFIRMATION RESOLUTIONS

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

- 30
31 • Resolution 204 – AMA Position on Payment Provisions in Health Insurance Policies
- 32 • Resolution 209 – Federal Government Regulation and Promoting Patient Access to
- 33 Kidney Transplantation
- 34 • Resolution 218 – Private Payers and Cognitive Care Services
- 35 • Resolution 306 – Financial Burden of USMLE Step 2 CS on Medical Students
- 36 • Resolution 803 – Encourage Federal Efforts to Expand Access to Scheduled Dialysis for
- 37 Undocumented People
- 38 • Resolution 804 – Protecting Seniors from Medicare Advantage Plans
- 39 • Resolution 809 – AMA Principles of Medicaid Reform
- 40 • Resolution 811 – Require Payers to Share Prior Authorization Cost Burden
- 41 • Resolution 813 – Public Reporting of PBM Rebates
- 42 • Resolution 814 – PBM Value-Based Framework for Formulary Design
- 43 • Resolution 816 – Definition of New Patient
- 44 • Resolution 817 – Transparency of Costs to Patients for Their Prescription Medications
- 45 Under Medicare Part D and Medicare Advantage Plans
- 46 • Resolution 911 – Basic Courses in Nutrition

- 1 • Resolution 916 – Sale of Tobacco in Retail Pharmacies
- 2 • Resolution 921 – Vaping in New York State and Nationally
- 3 • Resolution 927 – Climate Change
- 4 • Resolution 928 – CBD Oil and Supplement Use in Treatment
- 5 • Resolution 931 – Vaping Ban for Under 21 and Additional Regulations

Mister Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Thomas M. Anderson, Jr., MD, Mark N. Bair, MD, Jerome C. Cohen, MD, Gary A. Delaney, MD, Kyle P. Edmonds, MD, and Amit Ghose, MD, and on behalf of the committee those who appeared before the committee.

Thomas M. Anderson, Jr., MD
Illinois

Kyle P. Edmonds, MD
California

Mark N. Bair, MD
Utah

Amit Ghose, MD*
Michigan

Jerome C. Cohen, MD
New York

Cheryl Gibson-Fountain, MD, Chair
American College of Obstetricians and
Gynecologists

Gary A. Delaney, MD
South Carolina

* Alternate Delegate

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

- Resolution 204 – AMA Position on Payment Provisions in Health Insurance Policies
 - Authorized Assignment of Benefits D-390.995
- Resolution 209 – Federal Government Regulation and Promoting Patient Access to Kidney Transplantation
 - Assuring Patient Access to Kidney Transplantation, D-370.983
 - Cost-Saving Public Coverage for Renal Transplant Patients, H-370.963
 - UNOS Kidney Paired Donation Program, H-370.960
- Resolution 218 – Private Payers and Cognitive Care Services
 - Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917
 - Consultation Codes and Private Payers D-385.955
 - Medicare’s Proposal to Eliminate Payments for Consultation Service Codes D-70.953
 - Medicare Policy Change H-390.884
 - Non- Medicare Use of the RBRVS D-400.999
- Resolution 306 – Financial Burden of USMLE Step 2 CS on Medical Students
 - Clinical Skills Assessment During Medical School D-295.988
- Resolution 803 – Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People
 - Health Care Payment for Undocumented Persons D-440.985
 - Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
 - Addressing Immigrant Health Disparities H-350.957
 - In addition, the AMA continues to advocate on behalf of the health care needs of undocumented persons. For example, in a 2018 letter to the Department of Homeland Security, the AMA emphasized the importance of access to health care services for individuals and families who are seeking admission into the U.S., an extension of stay, or change in immigration status. More recently, the AMA sent a letter to President Trump raising concerns with the Presidential Proclamation on the Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System.
- Resolution 804 – Protecting Seniors from Medicare Advantage Plans
 - Ban on Medicare Advantage "No Cause" Network Terminations H-285.902
 - In addition, the AMA has directly engaged with the Centers for Medicare and Medicaid Services (CMS) regarding the need for improved tools for Medicare patients to more easily and accurately compare plans, including fee-for-service and Medicare Advantage (MA) plans. The AMA recommended to CMS that it adopt a suite of policy proposals to enhance network directory accuracy, network adequacy, network stability, and communication with patients about MA plans’ physician networks. Specifically, the AMA urged CMS to ensure that the Medicare Physician Finder website is user-friendly and encouraged CMS to create a plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients. Moreover, the AMA highlighted that

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

patients need to know whether they will need to keep changing physicians if they choose a particular MA plan due to networks changing significantly from year-to-year. Additionally, the AMA urged CMS to initiate a Network Adequacy Task Force that would allow CMS to engage on a regular basis with multiple stakeholders, including MA network physicians and Medicare patients or their representatives, to review current policies and develop new policies to address current issues with MA plans and comparisons.

- Resolution 809 – AMA Principles of Medicaid Reform
 - Medical Care for Patients with Low Incomes H-165.855
 - Affordable Care Act Medicaid Expansion H-290.965
 - Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
 - Selective Revenue Taxation of Physicians and Other Health Care Providers H-385.925
 - Insurance Company Denial of Payment for Office Visit and Invasive Procedure Done on the Same Day H-385.944
 - Medicaid Expansion D-290.979
- Resolution 811 – Require Payers to Share Prior Authorization Cost Burden
 - Prior Authorization and Utilization Management Reform H-320.939
 - Remuneration for Physician Services H-385.951
 - In addition, prior authorization and utilization management programs are a high-priority advocacy target for the AMA. The AMA regularly works with state medical associations and national medical specialty societies to address issues with prior authorization. Moreover, in 2017, the AMA partnered with 16 other organizations representing physicians, hospitals, pharmacists, and patients to develop the Prior Authorization and Utilization Management Reform Principles. In response, the AMA has undertaken an extensive advocacy campaign based on the Principles and ongoing research on prior authorization to further support this work. The work includes the annual survey of physicians, grassroots activities like FixPriorAuth.org for patient and physician involvement, robust participation in various standards organizations looking to streamline processes, consistent advocacy with CMS, supporting legislative reforms, social media advocacy, and the creation of and support for model state legislation throughout federation advocacy efforts. As summarized, the AMA is committed to continuing its extensive advocacy campaign based on the Principles and ongoing research on prior authorization burdens to further support this work.
- Resolution 813 – Public Reporting of PBM Rebates
 - The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
 - Pharmaceutical Costs H-110.987
 - In addition, the AMA is already advocating on the federal and state levels for the disclosure of pharmacy benefit manager (PBM) rebates and discounts. In a letter to Senator Lamar Alexander, chairman of the Senate Committee on Health, Labor, Education and Pensions, the AMA stated that, in order to improve PBM

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

transparency, “the disclosure of rebate and discount information, financial incentive information, and pharmacy and therapeutics committee information would constitute critical steps forward.” These concerns were echoed in comments of the AMA submitted in response to American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs (Blueprint) in July 2018.

- Concerning state-level advocacy, the AMA developed model state legislation entitled, “An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year” (AMA Model Act), which addresses the issues of stabilized formularies and cost transparency. In particular, the AMA Model Act requires PBMs operating in the state to disclose any discounts or other financial consideration they received that affect the price and cost-sharing of covered medicines placed on a formulary.
 - Finally, to expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, TruthinRx.org, in 2016. Nearly 350,000 individuals have signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign also generating more than one million messages sent to Congress demanding drug price transparency.
- Resolution 814 – PBM Value-Based Framework for Formulary Design
 - Patient Access to Treatments Prescribed by Their Physicians H-120.988
 - Expanded Use of the AMA's Principles of a Sound Drug Formulary H-125.985
 - Drug Formularies and Therapeutic Interchange H-125.991
 - Incorporating Value into Pharmaceutical Pricing H-110.986
 - Managed Care Cost Containment Involving Prescription Drugs H-285.965
 - Resolution 816 – Definition of New Patient
 - Use of CPT Editorial Panel Process H-70.919
 - Update on Revision of CPT E&M Codes and Development of Clinical Examples H-70.921
 - Primary Health Care Reimbursement Coding H-70.982
 - Notably, CPT defines a new patient as one who has not received any professional services from the physician within the past three years. Any changes to this definition would need to be made via the CPT Editorial Panel process, which provides for meaningful input from interested state medical associations and national medical specialty societies.
 - Resolution 817 – Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans
 - Endorse Medicare Part D Educational Website D-330.912
 - Medicare Cost-Sharing D-330.951
 - Private Health Insurance Formulary Transparency H-125.979

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- Resolution 911 – Basic Courses in Nutrition
 - Availability of Heart-Healthy and Health-Promoting Foods at AMA Functions, H-150.964
 - Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles, H-405.959
 - Basic Courses in Nutrition, H-150.995
- Resolution 916 – Sale of Tobacco in Retail Pharmacies
 - Banning the Sale of Tobacco Products in Pharmacies and Health Care Facilities, H-495.977
 - Oppose Sale of Tobacco Products in Pharmacies, D-495.994
 - Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes, H-495.986
- Resolution 921 – Vaping in New York State and Nationally
 - FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products, H-495.973
 - Cannabis and Cannabinoid Research, H-95.952
- Resolution 927 – Climate Change
 - Global Climate Change and Human Health, H-135.938
 - AMA Advocacy for Environmental Sustainability and Climate, H-135.923
- Resolution 928 – CBD Oil and Supplement Use in Treatment
 - Cannabis and Cannabinoid Research, H-95.952
 - Cannabis Legalization for Medicinal Use, D-95.969
- Resolution 931 – Vaping Ban for Under 21 and Additional Regulations
 - Opposition to Addition of Flavors to Tobacco Products, H-495.971
 - FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products, H-495.973
 - Oppose Efforts to Stop, Weaken or Delay FDA's Authority to Regulate All Tobacco Products, D-495.993
 - Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes, H-495.986

SUMMARY OF FISCAL NOTES (I-19)

BOT Report(s)

- 01 Legalization of the Deferred Action for Legal Childhood Arrival (DALCA): Minimal
- 02 Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings: Modest
- 03 Restriction on IMG Moonlighting: Minimal
- 04 Involvement of Women in AMA Leadership, Recognition and Research Opportunities: Informational report
- 05 Restrictive Covenants of Large Health Care Systems: Informational report
- 06 Physician Health Policy Opportunity: Modest
- 07 2019 AMA Advocacy Efforts: Informational report
- 08 Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership: None
- 09 Opioid Mitigation: Minimal
- 11 Re-establishment of National Guideline Clearinghouse: Informational report
- 12 Distracted Driver Education and Advocacy: Informational report
- 13 Hospital Closures and Physician Credentialing: Informational report
- 14 Redefining AMA's Position on ACA and Healthcare Reform: Informational report
- 15# Repealing Potential Penalties Associated with MIPS Resolution; Reducing the Regulatory Burden in Health Care; Improving the Quality Payment Program and Preserving Patient Access: Minimal
- 16# TIME'S UP Healthcare: Informational Report
- 17# Specialty Society Representation in the House of Delegates - Five-Year Review: Minimal
- 18# AMA's Immigration Advocacy Efforts: Informational Report

CC&B Report(s)

- 01 Parity in our House of Delegates: Minimal
- 02 Bylaw Consistency--Certification Authority for Societies represented in our AMA House of Delegates and Advance Certification for those Societies: Minimal
- 03 AMA Delegate Apportionment: Minimal

CEJA Report(s)

- 01 Competence, Self-Assessment and Self-Awareness: Minimal
- 02 Amendment to E-1.2.2., "Disruptive Behavior by Patients": Minimal

CLRPD Report(s)

- 01 Academic Physicians Section Five-Year Review: Minimal

CME Report(s)

- 01 For-Profit Medical Schools or Colleges: Informational Report
- 02 Healthcare Finance in the Medical School Curriculum: Minimal
- 03 Standardization of Medical Licensing Time Limits Across States: Minimal
- 04 Board Certification Changes Impact Access to Addiction Medicine Specialists: Minimal
- 05 The Transition from Undergraduate Medical Education to Graduate Medical Education: Informational Report
- 06 Veterans Health Administration Funding of Graduate Medical Education: Minimal

CMS Report(s)

- 01 Established Patient Relationships and Telemedicine: Minimal

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CMS Report(s)

- 02 Addressing Financial Incentives to Shop for Lower-Cost Health Care: Minimal
- 03 Improving Risk Adjustment in Alternative Payment Models: Minimal
- 04 Mechanisms to Address High and Escalating Pharmaceutical Prices: Minimal

CSAPH Report(s)

- 01 Mandatory Reporting of Diseases and Conditions: Minimal
- 02 Real-World Data and Real-World Evidence in Medical Product Decision Making: \$50,000
- 03 Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals: Minimal

HOD Comm on Compensation of the Officers

- 01* Report of the HOD Committee on Compensation of the Officers: Est. annual cost of \$49,950 based on data reported for July 1, 2018 through June 30, 2019. This cost represents the impact of the Governance Honorarium increase, the Per Diem increase, and the Telephonic Per Diem increase.

Report of the Speakers

- 01* Speakers' Report: Task Force on Election Reform: Informational Report

Resolution(s)

- 001 Support for the Use of Psychiatric Advance Directives: Minimal
- 002 Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training: Modest
- 003 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities: Minimal
- 004 Improving Inclusiveness of Transgender Patients Within Electronic Medical Record Systems: Minimal
- 005 Removing Sex Designation from the Public Portion of the Birth Certificate: Minimal
- 006 Transparency Improving Informed Consent for Reproductive Health Services: Minimal
- 007 Addressing the Racial Pay Gap in Medicine: Minimal
- 009 Data for Specialty Society Five-Year Review: Minimal
- 010 Ban Conversion Therapy of LGBTQ Youth: Modest
- 011 End Child Marriage: Modest
- 201 Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities: Minimal
- 202 Support for Veterans Courts: Minimal
- 203 Support Expansion of Good Samaritan Laws: Minimal
- 204 AMA Position on Payment Provisions in Health Insurance Policies: Modest
- 205 Co-Pay Accumulators: Modest
- 206 Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians: Minimal
- 207 Pharmaceutical Advertising in Electronic Health Record Systems: Modest
- 208 Net Neutrality and Public Health: Modest
- 209 Federal Government Regulation and Promoting Patient Access to Kidney Transplantation: Modest
- 210 Federal Government Regulation and Promoting Renal Transplantation: Modest
- 211 Effects of Net Neutrality on Public Health: Minimal
- 212 Centers for Medicare and Medicaid Services Open Payments Program: Modest
- 213 Data Completeness and the House of Medicine: Modest
- 214 AMA Should Provide a Summary of its Advocacy Efforts on Surprise Medical Bills: Modest

SUMMARY OF FISCAL NOTES (I-19)

Resolution(s)

- 215* Board Certification of Physician Assistants: Minimal
- 216* Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid: Minimal
- 217* Promoting Salary Transparency Among Veterans Health Administration Employed Physicians: Modest
- 218* Private Payers and Office Visit Policies: Modest
- 219* QPP and the Immediate Availability of Results in CEHRTs: Modest
- 220# Oppose Mandatory DNA Collection of Migrants: Minimal
- 221# Safe Supervision of Complex Radiation Oncology Therapeutic Procedures: Modest
- 301 Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools: Minimal
- 302 Strengthening Standards for LGBTQ Medical Education: Minimal
- 303 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations: Modest
- 304 Issues with the Match, The National Residency Matching Program (NRMP): Modest
- 305 Ensuring Access to Safe and Quality Care for our Veterans: Minimal
- 306 Financial Burden of USMLE Step 2 CS on Medical Students: Modest
- 307 Implementation of Financial Education Curriculum for Medical Students and Physicians in Training: Modest
- 308 Study Expediting Entry of Qualified IMG Physicians to US Medical Practice: Modest
- 309# Follow-up on Abnormal Medical Test Findings: Minimal
- 310# Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closures: Modest
- 602# Preserving Childcare at AMA Meetings: Indeterminate
- 801 Reimbursement for Post-Exposure Protocol for Needlestick Injuries: Modest
- 802 Ensuring Fair Pricing of Drugs Developed with the United States Government: Minimal
- 803 Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People: Minimal
- 804 Protecting Seniors from Medicare Advantage Plans: Modest
- 805 Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard: Modest
- 806 Support for Housing Modification Policies: Minimal
- 807 Addressing the Need for Low Vision Aid Devices: Minimal
- 808 Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs: Modest
- 809 AMA Principles of Medicaid Reform: Modest
- 810 Hospital Medical Staff Policy: Minimal
- 811 Require Payers to Share Prior Authorization Cost Burden: Minimal
- 812* Autopsy Standards as Condition of Participation: Modest
- 813* Public Reporting of PBM Rebates: Modest
- 814* PBM Value-Based Framework for Formulary Design: Modest
- 815* Step Therapy: Modest
- 816# Definition of New Patient: Modest
- 817# Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans: Modest
- 818# Medical Center Auto Accept Policies: Modest
- 819# Hospital Website Voluntary Physician Inclusion: Modest
- 820# E-Cigarette and Vaping Associated Illness: Modest
- 901 Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water: Minimal
- 902 Amending H-490.913, Smoke-Free Environments and Workplaces, and H-409.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to Include E-Cigarettes: Minimal

SUMMARY OF FISCAL NOTES (I-19)

Resolution(s)

- 903 Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications: Minimal
- 904 Amendment to AMA Policy H-150.949, "Healthy Food Options in Hospitals": Minimal
- 905 Sunscreen Dispensers in Public Spaces as a Public Health Measure: Minimal
- 906 Ensuring the Best In-School Care for Children with Sickle Cell Disease: Minimal
- 907 Increasing Access to Gang-Related Laser Tattoo Removal in Prison and Community Settings: Minimal
- 908 Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians: Minimal
- 909 Decreasing the Use of Oximetry Monitors for the Prevention of Sudden Infant Death Syndrome: Minimal
- 910 Ban on Electronic Nicotine Delivery System (ENDS) Products: Modest
- 911 Basic Courses in Nutrition: Minimal
- 912 Improving Emergency Response Planning for Infectious Disease Outbreaks: Minimal
- 913 Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use: Modest
- 914 Nicotine Replacement Therapy for Minors: Modest
- 915 Preventing Death and Disability Due to Particulate Matter Produced by Automobiles: Minimal
- 916 Sale of Tobacco in Retail Pharmacies: Minimal
- 917 Supporting Research Into the Therapeutic Potential of Psychedelics: Minimal
- 918 Banning Flavors, Including Menthol and Mint, in Combustible and Electronic Cigarettes and Other Nicotine Products: Minimal
- 919 Raising Awareness of the Health Impact of Cannabis: Modest
- 920 Maintaining Public Focus on Leading Causes of Nicotine-Related Death: Minimal
- 921 Vaping in New York State and Nationally: Minimal
- 922 Understanding the Effects of PFAS on Human Health: Minimal
- 923 Support Availability of Public Transit System: Minimal
- 924 Update Scheduled Medication Classification: Minimal
- 925* Suspending Sales of Vaping Products/Electronic Cigarettes Until FDA Review: Minimal
- 927* Climate Change: Minimal
- 928* CBD Oil and Supplement Use in Treatment: Minimal
- 929* Regulating Marketing and Distribution of Tobacco Products and Vaping-Related Products: Minimal
- 930# Origin of Prescription Medication Production Transparency: Minimal
- 931# Vaping Ban for Under 21 and Additional Regulations: Minimal
- 932# Source and Quality of Medications Critical to National Health and Security: Minimal
- 933# Supporting Research Into the Therapeutic Potential of Psychedelics: Minimal
- 934# Gun Violence and Mental Illness Stigma in the Media: Minimal
- 935# AMA Response to a National Vaping Epidemic: AMA currently does not have materials in order to implement the 4th Resolved. We will require sufficient funding to create the material referenced in Resolved 4.

Resolutions not for consideration

- 008 Improving the Health and Safety of Consensual Sex Workers: Minimal
- 012* Study of Forced Organ Harvesting by China: Modest
- 601 Amending AMA Policy G-630.140, "Lodging, Meeting Venues, and Social Functions": Minimal
- 926* School Resource Officer Qualifications and Training: Minimal

SUMMARY OF FISCAL NOTES (I-19)

Minimal - less than \$1,000

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

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

**ORDER OF BUSINESS
SECOND SESSION**

**Sunday, November 17, 2019
8:00 AM**

1. Report of the Committee on Rules and Credentials - Cheryl Gibson-Fountain, MD, Chair
2. Presentation, Correction and Adoption of Minutes of the 2019 Annual Meeting
3. Reports of the Board of Trustees - Jesse M. Ehrenfeld, MD, MPH, Chair
 - 01 Legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (B)
 - 02 Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings (B)
 - 03 Restriction on IMG Moonlighting (B)
 - 04 Involvement of Women in AMA Leadership, Recognition and Research Opportunities (Info. Report)
 - 05 Restrictive Covenants of Large Health Care Systems (Info. Report)
 - 06 Physician Health Policy Opportunity (F)
 - 07 2019 AMA Advocacy Efforts (Info. Report)
 - 08 Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership (F)
 - 09 Opioid Mitigation (B)
 - 11 Re-establishment of National Guideline Clearinghouse (Info. Report)
 - 12 Distracted Driver Education and Advocacy (Info. Report)
 - 13 Hospital Closures and Physician Credentialing (Info. Report)
 - 14 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
 - 15# Repealing Potential Penalties Associated with MIPS Resolution; Reducing the Regulatory Burden in Health Care; Improving the Quality Payment Program and Preserving Patient Access (B)
 - 16# TIME'S UP Healthcare (Info. Report)
 - 17# Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)
 - 18# AMA's Immigration Advocacy Efforts (Info. Report)
4. Reports of the Council on Constitution and Bylaws - Patricia L. Austin, MD, Chair
 - 01 Parity in our House of Delegates (Amendments to C&B)
 - 02 Bylaw Consistency--Certification Authority for Societies represented in our AMA House of Delegates and Advance Certification for those Societies (Amendments to C&B)
 - 03 AMA Delegate Apportionment (Amendments to C&B)
5. Reports of the Council on Ethical and Judicial Affairs - Kathryn L. Moseley, MD, Chair
 - 01 Competence, Self-Assessment and Self-Awareness (Amendments to C&B)
 - 02 Amendment to E-1.2.2., "Disruptive Behavior by Patients" (Amendments to C&B)
6. Report of the Council on Long Range Planning and Development - James A. Goodyear, MD, Chair
 - 01 Academic Physicians Section Five-Year Review (F)
7. Reports of the Council on Medical Education - Jacqueline A. Bello, MD, Chair
 - 01 For-Profit Medical Schools or Colleges (Info. Report)
 - 02 Healthcare Finance in the Medical School Curriculum (C)
 - 03 Standardization of Medical Licensing Time Limits Across States (C)
 - 04 Board Certification Changes Impact Access to Addiction Medicine Specialists (C)
 - 05 The Transition from Undergraduate Medical Education to Graduate Medical Education (Info. Report)

- 06 Veterans Health Administration Funding of Graduate Medical Education (C)
- 8. Reports of the Council on Medical Service - W. Alan Harmon, MD, Chair
 - 01 Established Patient Relationships and Telemedicine (J)
 - 02 Addressing Financial Incentives to Shop for Lower-Cost Health Care (J)
 - 03 Improving Risk Adjustment in Alternative Payment Models (J)
 - 04 Mechanisms to Address High and Escalating Pharmaceutical Prices (J)
- 9. Reports of the Council on Science and Public Health - Michael M. Miller, MD, Chair
 - 01 Mandatory Reporting of Diseases and Conditions (K)
 - 02 Real-World Data and Real-World Evidence in Medical Product Decision Making (K)
 - 03 Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals (K)
- 10. Report of the HOD Committee on Compensation of the Officers - Richard A. Evans, MD, Chair
 - 01* Report of the HOD Committee on Compensation of the Officers (F)
- 11. Report of the Speakers - Bruce A. Scott, MD, Speaker; Lisa Bohman Egbert, MD, Vice Speaker
 - 01* Speakers' Report: Task Force on Election Reform (Info. Report)
- 12. Extraction of Informational Reports
- 13. Introduction of Resolutions
 - 001 Support for the Use of Psychiatric Advance Directives (Amendments to C&B)
 - 002 Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training (Amendments to C&B)
 - 003 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities (Amendments to C&B)
 - 004 Improving Inclusiveness of Transgender Patients Within Electronic Medical Record Systems (Amendments to C&B)
 - 005 Removing Sex Designation from the Public Portion of the Birth Certificate (Amendments to C&B)
 - 006 Transparency Improving Informed Consent for Reproductive Health Services (Amendments to C&B)
 - 007 Addressing the Racial Pay Gap in Medicine (Amendments to C&B)
 - 009 Data for Specialty Society Five-Year Review (Amendments to C&B)
 - 010 Ban Conversion Therapy of LGBTQ Youth (Amendments to C&B)
 - 011 End Child Marriage (Amendments to C&B)
 - 201 Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities (B)
 - 202 Support for Veterans Courts (B)
 - 203 Support Expansion of Good Samaritan Laws (B)
 - 204 AMA Position on Payment Provisions in Health Insurance Policies (B)
 - 205 Co-Pay Accumulators (B)
 - 206 Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians (B)
 - 207 Pharmaceutical Advertising in Electronic Health Record Systems (B)
 - 208 Net Neutrality and Public Health (B)
 - 209 Federal Government Regulation and Promoting Patient Access to Kidney Transplantation (B)
 - 210 Federal Government Regulation and Promoting Renal Transplantation (B)
 - 211 Effects of Net Neutrality on Public Health (B)
 - 212 Centers for Medicare and Medicaid Services Open Payments Program (B)
 - 213 Data Completeness and the House of Medicine (B)
 - 214 AMA Should Provide a Summary of its Advocacy Efforts on Surprise Medical Bills (B)

215* Board Certification of Physician Assistants (B)

216* Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid (B)

217* Promoting Salary Transparency Among Veterans Health Administration Employed Physicians (B)

218* Private Payers and Office Visit Policies (B)

219* QPP and the Immediate Availability of Results in CEHRTs (B)

220# Oppose Mandatory DNA Collection of Migrants (B)

221# Safe Supervision of Complex Radiation Oncology Therapeutic Procedures (B)

301 Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools (C)

302 Strengthening Standards for LGBTQ Medical Education (C)

303 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations (C)

304 Issues with the Match, The National Residency Matching Program (NRMP) (C)

305 Ensuring Access to Safe and Quality Care for our Veterans (C)

306 Financial Burden of USMLE Step 2 CS on Medical Students (C)

307 Implementation of Financial Education Curriculum for Medical Students and Physicians in Training (C)

308 Study Expediting Entry of Qualified IMG Physicians to US Medical Practice (C)

309# Follow-up on Abnormal Medical Test Findings (C)

310# Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closures (C)

602# Preserving Childcare at AMA Meetings (F)

801 Reimbursement for Post-Exposure Protocol for Needlestick Injuries (J)

802 Ensuring Fair Pricing of Drugs Developed with the United States Government (J)

803 Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People (J)

804 Protecting Seniors from Medicare Advantage Plans (J)

805 Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard (J)

806 Support for Housing Modification Policies (J)

807 Addressing the Need for Low Vision Aid Devices (J)

808 Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs (J)

809 AMA Principles of Medicaid Reform (J)

810 Hospital Medical Staff Policy (J)

811 Require Payers to Share Prior Authorization Cost Burden (J)

812* Autopsy Standards as Condition of Participation (J)

813* Public Reporting of PBM Rebates (J)

814* PBM Value-Based Framework for Formulary Design (J)

815* Step Therapy (J)

816# Definition of New Patient (J)

817# Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans (J)

818# Medical Center Auto Accept Policies (J)

819# Hospital Website Voluntary Physician Inclusion (J)

820# E-Cigarette and Vaping Associated Illness (J)

901 Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water (K)

902 Amending H-490.913, Smoke-Free Environments and Workplaces, and H-409.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to Include E-Cigarettes (K)

903 Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications (K)

- 904 Amendment to AMA Policy H-150.949, "Healthy Food Options in Hospitals" (K)
- 905 Sunscreen Dispensers in Public Spaces as a Public Health Measure (K)
- 906 Ensuring the Best In-School Care for Children with Sickle Cell Disease (K)
- 907 Increasing Access to Gang-Related Laser Tattoo Removal in Prison and Community Settings (K)
- 908 Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians (K)
- 909 Decreasing the Use of Oximetry Monitors for the Prevention of Sudden Infant Death Syndrome (K)
- 910 Ban on Electronic Nicotine Delivery System (ENDS) Products (K)
- 911 Basic Courses in Nutrition (K)
- 912 Improving Emergency Response Planning for Infectious Disease Outbreaks (K)
- 913 Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use (K)
- 914 Nicotine Replacement Therapy for Minors (K)
- 915 Preventing Death and Disability Due to Particulate Matter Produced by Automobiles (K)
- 916 Sale of Tobacco in Retail Pharmacies (K)
- 917 Supporting Research Into the Therapeutic Potential of Psychedelics (K)
- 918 Banning Flavors, Including Menthol and Mint, in Combustible and Electronic Cigarettes and Other Nicotine Products (K)
- 919 Raising Awareness of the Health Impact of Cannabis (K)
- 920 Maintaining Public Focus on Leading Causes of Nicotine-Related Death (K)
- 921 Vaping in New York State and Nationally (K)
- 922 Understanding the Effects of PFAS on Human Health (K)
- 923 Support Availability of Public Transit System (K)
- 924 Update Scheduled Medication Classification (K)
- 925* Suspending Sales of Vaping Products/Electronic Cigarettes Until FDA Review (K)
- 927* Climate Change (K)
- 928* CBD Oil and Supplement Use in Treatment (K)
- 929* Regulating Marketing and Distribution of Tobacco Products and Vaping-Related Products (K)
- 930# Origin of Prescription Medication Production Transparency (K)
- 931# Vaping Ban for Under 21 and Additional Regulations (K)
- 932# Source and Quality of Medications Critical to National Health and Security (K)
- 933# Supporting Research Into the Therapeutic Potential of Psychedelics (K)
- 934# Gun Violence and Mental Illness Stigma in the Media (K)
- 935# AMA Response to a National Vaping Epidemic (K)

14. Changes in Reference Committees

15. Presentation of Items Recommended Against Consideration

- 008 Improving the Health and Safety of Consensual Sex Workers (Not for consideration)
- 012* Study of Forced Organ Harvesting by China (Not for consideration)
- 601 Amending AMA Policy G-630.140, "Lodging, Meeting Venues, and Social Functions" (Not for consideration)
- 926* School Resource Officer Qualifications and Training (Not for consideration)

16. Memorial Resolutions

17. Report of the Committee on Rules and Credentials - Cheryl Gibson-Fountain, MD, Chair

- Late Resolutions

- Proposed Reaffirmations

18. Unfinished Business and Announcements - Bruce A. Scott, MD

** contained in the Handbook Addendum*

contained in the Sunday Tote

ORDER OF BUSINESS

Reference Committee on Amendments to Constitution and Bylaws (I-19)
David Walsworth, MD, Chair

November 14, 2019
Grand Hall D

Manchester Grand Hyatt San Diego
San Diego

1. Board of Trustees Report 17 – Specialty Society Representation in the House of Delegates - Five-Year Review
2. Council on Constitution and Bylaws Report 1 – Parity in our House of Delegates
3. Council on Constitution and Bylaws Report 2 – Bylaw Consistency--Certification Authority for Societies Represented in our AMA House of Delegates and Advance Certification for those Societies
4. Council on Constitution and Bylaws Report 3 – AMA Delegate Apportionment
5. Council on Ethical and Judicial Affairs Report 1 – Competence, Self-Assessment and Self-Awareness
6. Council on Ethical and Judicial Affairs Report 2 - Amendment to E-1.2.2., "Disruptive Behavior by Patients"
7. Resolution 001 – Support for the Use of Psychiatric Advance Directives
8. Resolution 002 – Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training
9. Resolution 003 – Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities
10. Resolution 004 – Improving Inclusiveness of Transgender Patients Within Electronic Medical Record Systems
11. Resolution 005 – Removing Sex Designation from the Public Portion of the Birth Certificate
12. Resolution 006 – Transparency Improving Informed Consent for Reproductive Health Services
13. Resolution 007 – Addressing the Racial Pay Gap in Medicine

Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

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

14. *Resolution 008 – Improving the Health and Safety of Consensual Sex Workers*
15. Resolution 009 – Data for Specialty Society Five-Year Review
16. Resolution 010 – Ban Conversion Therapy of LGBTQ Youth
17. Resolution 011 – End Child Marriage
18. *Resolution 012 – Study of Forced Organ Harvesting by China*

Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

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ORDER OF BUSINESS

Reference Committee B (I-19)
Cyndi Yag-Howard, MD, Chair

November 17, 2019
Harbor Ballroom G-I

Manchester Grand Hyatt
San Diego, CA

1. Board of Trustees Report 01 – Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
2. Board of Trustees Report 03 – Restriction on IMG Moonlighting
3. Resolution 206 – Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians
4. Resolution 220 – Oppose Mandatory DNA Collection of Migrants
5. Board of Trustees Report 02 – Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
6. Board of Trustees Report 09 – Opioid Mitigation
7. Resolution 201 – Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities
8. Resolution 203 – Support Expansion of Good Samaritan Laws
9. Board of Trustees Report 15 – Repealing Potential Penalties Associated with MIPS (Resolution 206-I-18), Reducing the Regulatory Burden in Health Care (Resolution 231-I-18), Improving the Quality Payment Program and Preserving Patient Access (Resolution 243-A-19)
10. Resolution 202 – Support for Veterans Courts
11. *Resolution 204 – AMA Position on Payment Provisions in Health Insurance Policies*
12. Resolution 205 – Co-Pay Accumulators
13. Resolution 207 – Pharmaceutical Advertising in Electronic Health Record Systems
14. Resolution 208 – Net Neutrality and Public Health
Resolution 211 – Effects of Net Neutrality on Public Health
15. *Resolution 209 – Federal Government Regulation and Promoting Patient Access to Kidney Transplantation*
Resolution 210 – Federal Government Regulation and Promoting Renal Transplantation
16. Resolution 212 – Centers for Medicare and Medicaid Services Open Payments Program
17. Resolution 213 – Data Completeness and the House of Medicine
18. Resolution 214 – AMA Should Provide a Summary of its Advocacy Efforts on Surprise Medical Bill
19. *Resolution 215 – Board Certification of Physician Assistants*
20. Resolution 221 – Safe Supervision of Complex Radiation Oncology Therapeutic Procedures
21. *Late Resolution 1001 – State Board Scope of Practice Expansion Beyond Statute*
22. *Resolution 216 – Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid*
23. Resolution 217 – Promoting Salary Transparency Among Veterans Health Administration Employed Physicians

- 24. Resolution 219 – QPP and the Immediate Availability of Results in CEHRTs
- 25. *Late Resolution 1002 – Appropriate Use of Scientific Studies and Data in the Development of Public Policy*

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

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

ORDER OF BUSINESS

Reference Committee C (I-19)
Louito C. Edje, MD, Chair

November 17, 2019
Harbor Ballroom A-C

Manchester Grand Hyatt
San Diego

1. Council on Medical Education Report 2, Healthcare Finance in the Medical School Curriculum (Resolution 307-A-18)
2. Resolution 307, Implementation of Financial Education Curriculum for Medical Students and Physicians in Training
3. Resolution 302, Strengthening Standards for LGBTQ Medical Education
4. Resolution 303, Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations
5. Resolution 301, Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools
6. *Resolution 306, Financial Burden of USMLE Step 2 CS on Medical Students*
7. Resolution 304, Issues with the Match, the National Residency Matching Program (NRMP)
8. Resolution 310, Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure
9. Council on Medical Education Report 3, Standardization of Medical Licensing Time Limits Across States (Resolution 305-A-18)
10. Resolution 308, Study Expediting Entry of Qualified IMG Physicians to US Medical Practice
11. Council on Medical Education Report 6, Veterans Health Administration Funding of Graduate Medical Education (Resolution 954-I-18)
12. Resolution 305, Ensuring Access to Safe and Quality Care for our Veterans
13. Council on Medical Education Report 4, Board Certification Changes Impact Access to Addiction Medicine Specialists (Resolution 314-A-18)
14. Resolution 309, Follow-up on Abnormal Medical Test Findings

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

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

ORDER OF BUSINESS

Reference Committee F (I-19)

Ann R. Stroink, MD, Chair

November 17, 2019
Seaport Ballroom

Manchester Grand Hyatt San Diego
San Diego

1. Report of the House of Delegates Committee on Compensation of the Officers
2. Board of Trustees Report 6 – Physician Health Policy Opportunity
3. Board of Trustees Report 8 – Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership
4. Council on Long Range Planning and Development Report 1 – Academic Physicians Section Five-Year Review
5. Resolution 602 – Preserving Childcare at AMA Meetings
6. *Resolution 601 – Amending AMA Policy G-630.140, “Lodging, Meeting Venues, and Social Functions”*

Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

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

ORDER OF BUSINESS

Reference Committee J (I-19)
Ravi Goel, MD, Chair

November 17, 2019
Harbor Ballroom D-F

Manchester Grand Hyatt San Diego
San Diego

1. Council on Medical Service Report 1 – Established Patient Relationships and Telemedicine
2. Council on Medical Service Report 2 – Addressing Financial Incentives to Shop for Lower-Cost Health Care
3. Council on Medical Service Report 3 – Improving Risk Adjustment in Alternative Payment Models
4. Council on Medical Service Report 4 – Mechanisms to Address High and Escalating Pharmaceutical Prices
Resolution 802 – Ensuring Fair Pricing of Drugs Developed with the United States Government
Resolution 805 – Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard
5. Resolution 801 – Reimbursement for Post-Exposure Protocol for Needlestick Injuries
6. *Resolution 804 – Protecting Seniors from Medicare Advantage Plans*
7. *Resolution 817 – Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans*
8. Resolution 807 – Addressing the Need for Low Vision Aid Devices
9. Resolution 806 – Support for Housing Modification Policies
10. Resolution 808 – Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs
11. *Resolution 803 – Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People*
12. *Resolution 809 – AMA Principles of Medicaid Reform*
13. *Resolution 816 – Definition of New Patient*

Note: Items in italics were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

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14. Resolution 820 – E-Cigarette and Vaping Associated Illness
15. *Resolution 811 – Require Payers to Share Prior Authorization Cost Burden*
16. *Resolution 813 – Public Reporting of PBM Rebates*
17. *Resolution 814 – PBM Value-Based Framework for Formulary Design*
18. Resolution 815 – Step Therapy
19. Resolution 810 – Hospital Medical Staff Policy
20. Resolution 812 – Autopsy Standards as Condition of Participation
21. Resolution 819 – Hospital Website Voluntary Physician Inclusion
22. Resolution 818 – Medical Center Auto Accept Policies

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ORDER OF BUSINESS

Reference Committee K (I-19)
Alyn Adrain, MD, Chair

November 16, 2019
Grand Hall D

Manchester Grand Hyatt
San Diego

1. CSAPH Report 2, Real-World Data and Real-World Evidence in Medical Product Decision Making
2. Resolution 901, Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water
- Resolution 922, Understanding the Effects of PFAS on Human Health
3. Resolution 903, Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications
4. Resolution 904, Amendment to H-150.949, Healthy Food Options in Hospitals
5. *Resolution 911, Basic Courses in Nutrition*
6. Resolution 905, Sunscreen Dispensers in Public Spaces as a Public Health Measure
7. Resolution 906, Ensuring the Best In-School Care for Children with Sickle Cell Disease
8. Resolution 907, Increasing Access to Gang-Related Laser Tattoo Removal in Prison and Community Settings
9. Resolution 908, Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians
10. Resolution 909, Decreasing the Use of Oximetry Monitors for the Prevention of Sudden Infant Death Syndrome
11. Resolution 912, Improving Emergency Response Planning for Infectious Disease Outbreaks
12. CSAPH Report 1, Mandatory Reporting of Diseases and Conditions (Resolution 915-I-18)
13. Resolution 915, Preventing Death and Disability Due to Particulate Matter Produced by Automobiles
14. Resolution 917, Supporting Research into the Therapeutic Potential of Psychedelics
- Resolution 933, Supporting Research into the Therapeutic Potential of Psychedelics
15. Resolution 923, Support Availability of Public Transit Systems
16. Resolution 924, Update Scheduled Medication Classification
17. *Resolution 926, School Resource Officer Qualifications and Training*
18. *Resolution 927, Climate Change*
19. Resolution 930, Origin of Prescription Medication Production Transparency
- Resolution 932, Source and Quality of Medications Critical to National Health and Security
20. Resolution 934, Gun Violence and Mental Illness Stigma in the Media
21. *Resolution 928, CBD Oil and Supplement Use in Treatment*
22. CSAPH Report 3, Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals (Resolution 414-A-19)

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23. Resolution 913, Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use
24. Resolution 919, Raising Awareness of the Health Impact of Cannabis
24. Resolution 902, Amending H-490.913, Smoke-Free Environments and Workplaces, and H-409.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to Include E-Cigarettes
25. Resolution 910, Ban on Electronic Nicotine Delivery System (ENDS) Products
25. Resolution 925, Suspending Sales of Vaping Products / Electronic Cigarettes Until FDA Review
26. Resolution 914, Nicotine Replacement Therapy for Minors
27. *Resolution 916, Sale of Tobacco in Retail Pharmacies*
28. Resolution 918, Banning Flavors, Including Menthol and Mint, in Combustible and Electronic Cigarettes and Other Nicotine Products
29. Resolution 920, Maintaining Public Focus on Leading Causes of Nicotine-Related Death
30. *Resolution 921, Vaping in New York State and Nationally*
31. *Resolution 929, Regulating Marketing and Distribution of Tobacco Products and Vaping-Related Products*
32. Resolution 931, Vaping Ban for Under 21 and Additional Regulations
33. Resolution 935, AMA Response to a National Vaping Epidemic

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Report of the AMPAC Board of Directors

Presented by: Lyle Thorstenson, MD
Chair

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

AMPAC Membership Fundraising

A special thank you to those members who contributed to AMPAC in 2019. Your early support is important to our success and will help AMPAC continue to be effective this election cycle. AMPAC receipts for the cycle are nearing 1 million dollars and our success begins with you, the leaders in our House of Delegates. Currently, the HOD AMPAC participation stands at 74 percent and there is some work to be done as the House ended 2018 with a record-breaking 80 percent participation rate. There are 263 or 52 percent of HOD members who participate at the following Capitol Club levels: 25 Platinum members, 84 Gold members and 154 Silver members. If you have not made a 2019 contribution to AMPAC yet, I strongly encourage you to stop by the AMPAC booth today to join or renew your membership.

All current 2019 Capitol Club members have been invited to attend an exclusive Capitol Club Luncheon on Monday, November 18 with special guest Stephen Fried. Mr. Fried is an award-winning New York Times journalist, and his most recent work, *Rush*, is now a finalist for the George Washington Book Prize. AMPAC will be providing all 2019 Capitol Club Platinum members with a complimentary copy of *Rush* that can be signed by the author during their meet and greet opportunity prior to the Capitol Club luncheon from 11:30 am -12:00 pm in the Harbor Ballroom foyer.

During the Capitol Club luncheon, the lucky winner of AMPAC's 2019 *Off to the Races* Sweepstakes will be announced. Kentucky is the home to the first leg of the Triple Crown and is one of America's most spectacular horse racing events. The winner will receive round trip airfare for two and accommodations for 5 days/4 nights in beautiful downtown Lexington, Kentucky. This trip includes guided tours of famed local horse farms, distilleries and clubhouse level tickets to Derby races on Friday and Saturday. All 2019 Platinum, Gold and Silver contributors are automatically entered into the drawing for the sweepstakes.

Political Action

The 2020 Election season is upon us and AMPAC is working hard to leverage opportunities on medicine's behalf. Already this cycle, AMPAC has invested more than \$270,000 in political contributions, primarily to current members of Congress who are in leadership, sit on key committees, are true champions of medicine, and/or represent strategically important voting blocs of solutions-oriented legislators on both sides of the aisle. AMPAC is well-positioned to keep up and indeed exceed this pace as things heat up and targeted races take better shape heading into next year.

Health care issues continue to loom large in U.S. House and Senate races all over the country, and of course in the race for the White House, the debate over the future of America's health care delivery dominates the headlines. Partisan gridlock in Washington has left many issues important to medicine unresolved. Debates over how to address surprise billing, MACRA reform, drug price transparency, prior authorization abuses, and comprehensive reform approaches such as Medicare for All are expected to continue into next year's Congress and beyond. For AMPAC, this situation puts candidates running for federal office, and the positions they hold on these critical issues, into sharp focus.

The AMPAC Board's Congressional Review Committee will meet in February to set an initial budget for House and Senate candidates running this cycle. And as always, we are thoroughly researching competitive races and continuing to work closely with our colleagues in state medical societies and their political operations to help determine where AMPAC support will have the greatest impact on behalf of medicine. Factors that AMPAC weighs carefully in its decision-making process include race competitiveness, support for medicine's priority issues, and lawmakers in positions of leadership or on committees that most closely deal with legislation affecting physicians and their practices. AMPAC has also recently released its 2020 Candidate Survey. The candidate survey is another helpful tool, especially for first time candidates and challengers, to find out where candidates stand on the issues that matter most to medicine. The AMPAC 2020 Candidate Survey is given to all candidates contacting AMPAC and requesting support. It is also distributed to state medical societies and to the U.S. House and Senate party committees.

Political Education Programs

On September 26-29, physicians, medical students, physician spouses and state medical society staff from across the country took part in the 2019 Campaign School at the AMA offices in Washington, DC. As last year's elections confirmed, running an effective campaign can be the difference between winning and losing a race. The AMPAC Campaign School once again gave participants the skills and strategic approach they will need out on the campaign trail. Participants were placed into campaign teams and by using a hands-on approach our team of political experts ran them through a simulated campaign, teaching them everything they need to know to run a successful race.

AMPAC has also announced the dates for the 2020 Candidate Workshop which will take place February 28 – March 1 at the AMA offices in Washington, DC. During the one-and-a-half-day program, participants will learn what it takes to mount an effective run for office from our bi-partisan group of experts.

AMPAC will also be hosting a political education session at the AMA Interim Meeting. Titled "An Insiders 'How to' Guide to Running and Winning a Campaign," the hour-long session will provide an in-depth preview of the Candidate Workshop and how this intensive two-day program can prepare you with the tools you need to run a winning political campaign. The session will be held from 3-4pm on Sunday, November 17 in the Cortez Hill A/B meeting rooms.

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

Conclusion

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

Informational Reports

BOT Report(s)

- 04 Involvement of Women in AMA Leadership, Recognition and Research Opportunities
- 05 Restrictive Covenants of Large Health Care Systems
- 07 2019 AMA Advocacy Efforts
- 11 Re-establishment of National Guideline Clearinghouse
- 12 Distracted Driver Education and Advocacy
- 13 Hospital Closures and Physician Credentialing
- 14 Redefining AMA's Position on ACA and Healthcare Reform
- 16# TIME'S UP Healthcare
- 18# AMA's Immigration Advocacy Efforts

CME Report(s)

- 01 For-Profit Medical Schools or Colleges
- 05 The Transition from Undergraduate Medical Education to Graduate Medical Education

Report of the Speakers

- 01* Speakers' Report: Task Force on Election Reform

** Contained in Handbook Addendum*

Contained in Sunday Tote

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-I-19

Subject: TIME'S UP Healthcare

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

1 INTRODUCTION

2
3 At the 2019 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-65.988,
4 "TIME'S UP Healthcare," which directs our AMA to "evaluate the TIME'S UP Healthcare
5 program and consider participation as a TIME'S UP partner in support of our mutual objectives to
6 eliminate harassment and discrimination in medicine."
7

8 Testimony was supportive, recognizing that a relationship with TIME'S UP Healthcare could
9 advance AMA efforts to support women in medicine. At the same time, testimony recognized that
10 our AMA should not enter into such a relationship without first evaluating the organization and
11 considering how a partnership would impact the AMA's reputation and help the AMA achieve its
12 stated goals.
13

14 Since the 2019 Annual Meeting, our AMA has been in communication with the leadership of
15 TIME'S UP Healthcare to learn more about the organization and opportunities for collaboration.
16 This informational report provides background information on the organization and describes the
17 ways in which AMA might partner with TIME'S UP Healthcare to advance our common goal of
18 gender equity in medicine.
19

20 BACKGROUND

21
22 TIME'S UP Healthcare was launched in February 2019 with the mission "to unify national efforts
23 to bring safety, equity, and dignity to our healthcare workplace."¹ From this mission flow the
24 organization's goals:

- 25 • **"Unite healthcare workers across fields.** The problems of gender inequity and sexual
26 harassment affect all workers who provide health care. TIME'S UP Healthcare aims to
27 engage and support organizations and individuals at every level of health care delivery.
- 28 • **Improve care for targets of harassment and inequity.** Highlight the physical and mental
29 health sequelae of workplace harassment and identify ways to provide access to resources
30 for employees affected by it.
- 31 • **Raise awareness and knowledge.** Provide visibility to persistent gender inequities and
32 harassment in health care through data and through narratives. We will also provide
33 educational materials for training those in health care on how to combat gender inequity
34 and sexual harassment.
- 35 • **Support healthcare organizations in making this issue central and visible.** Invite major
36 healthcare organizations across the country to make an open and sustained commitment to
37 ending gender inequity and sexual harassment.

¹ Citations throughout this report are drawn from the TIME'S UP Healthcare website:
<https://www.timesuphealthcare.org/>.

- 1 • **Provide a link to the TIME'S UP Legal Defense Fund.** Strengthen the ability of limited-
2 resource and low-income workers to obtain legal aid through the TIME'S UP Legal
3 Defense Fund.
- 4 • **Advocate for meaningful standards.** Advocate for standards for policies, practices, and
5 outcomes that ensure organizations are effective in preventing and responding to gender
6 inequity and sexual harassment.
- 7 • **Advance research on harassment and inequity.** Serve as a repository for existing
8 research on gender inequity and sexual harassment in the healthcare industry and identify
9 and highlight critical gaps in the literature.”

10
11 TIME'S UP Healthcare is an affiliate of the TIME'S UP Foundation, a 501(c)(3) organization
12 advocating for safe, dignified, and fair workplaces. Other affiliates, which house working groups to
13 activate and engage a broader network of working women, include TIME'S UP Tech, TIME'S UP
14 Entertainment, and TIME'S UP UK. Other associated bodies include the TIME'S UP Legal
15 Defense Fund, which is administered by the National Women's Law Center, and the TIME'S UP
16 Impact Lab, the organization's 501(c)(4) research and policy center.

17
18 Although each affiliate is led by an Advisory Council, the activities of the overall organization
19 ultimately are directed by the TIME'S UP Global Board, which includes representatives from each
20 affiliate. The TIME'S UP Healthcare Advisory Council includes 12 healthcare executives, half of
21 whom are AMA members, and two of whom are leaders within the AMA Minority Affairs Section
22 and Women Physicians Section.

23
24 TIME'S UP Healthcare offers three categories for organizational collaboration:

- 25 • **Sponsors** are the only organizational entities that provide financial support. Current
26 sponsors include FIGS; feminem; Horizon Pharma; InCrowd; Rosh Review; and the
27 American Medical Women's Association.
- 28 • **Partners** work in close collaboration with TIME'S UP Healthcare to advance the common
29 goal of bringing equity and inclusion to the healthcare workforce. Current partners include
30 American College of Physicians, American Nurses Association, American Medical
31 Women's Association, Council of Medical Specialty Societies, National Medical
32 Association, and Service Employees International Union.
- 33 • **Signatories** (of which there are currently more than 40) are organizations that have
34 pledged their commitment to TIME'S UP Healthcare's core statements:
 - 35 ○ “Sexual harassment and gender inequity have no place in the healthcare workplace.
 - 36 ○ We are committed to preventing sexual harassment and gender inequity and
 - 37 protecting and aiding those who are targets of harassment and discrimination.
 - 38 ○ We believe every employee should have equitable opportunity, support, and
 - 39 compensation.
 - 40 ○ We cannot address a problem without understanding its scope and impact; we will
 - 41 measure and track sexual harassment and gender-based inequities occurring in our
 - 42 institution.”

43
44 Participation in any of these capacities requires a signed Memorandum of Understanding (MOU)
45 between TIME'S UP Healthcare and the collaborating organization.

1 DISCUSSION

2

3 Our AMA and TIME'S UP Healthcare share a dedication to advancing gender equity in medicine
4 (see for example, AMA Policies H-65.961, "Principles for Advancing Gender Equity in Medicine,"
5 and D-65.989, "Advancing Gender Equity in Medicine"), and our assessment of TIME'S UP
6 Healthcare leads us to believe that a partnership would strengthen both organizations' efforts in this
7 regard. Accordingly, your Board of Trustees will work with the leadership of TIME'S UP
8 Healthcare to specify the terms of a formal partnership that will enable our organizations to work
9 together to advance gender equity in medicine.

Relevant AMA Policy

H-65.961 Principles for Advancing Gender Equity in Medicine

Principles for Advancing Gender Equity in Medicine:

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. (BOT Rep. 27, A-19)

D-65.989 Advancing Gender Equity in Medicine

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.

(Res. 010, A-18 Modified: BOT Rep. 27, A-19)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-I-19

Subject: AMA's Immigration Advocacy Efforts

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

1 INTRODUCTION

2
3 The American Medical Association (AMA) has been, and continues to be, deeply committed to
4 ensuring the health and safety of all individuals regardless of immigration status. Through our
5 advocacy at the federal level, the AMA continues to advance policies that support, protect, and
6 promote immigrant health. This report provides a summary of AMA advocacy activities related to
7 certain immigration reform policies proposed by the federal government.
8

9 DISCUSSION

10 *Health and Safety Conditions at the Southern Border*

11
12
13 On April 6, 2018, the U.S. Department of Justice (DOJ) instituted Zero Tolerance, a policy to
14 prosecute violations of improper entry and attempted improper entry by an undocumented
15 immigrant. On May 5, 2018, in response to the DOJ's Zero Tolerance policy for illegal entry and
16 based on guidance from the U.S. Department of Homeland Security (DHS), the U.S. Customs and
17 Border Protection (CBP) began referring greater numbers of violations for prosecution. On June
18 19, 2018, the AMA sent a [letter](#) to the DHS, the U.S. Department of Health and Human Services
19 (HHS), and the DOJ, consistent with [AMA policy](#) adopted during the 2018 Annual Meeting of the
20 House of Delegates, urging the federal government to rescind its Zero Tolerance Policy which
21 resulted in the separation of children from their caregivers.¹ The AMA urged the Administration to
22 give priority to supporting families and protecting the health and well-being of the children within
23 those families.
24

25 On July 24, 2018, several national health care organizations, including the AMA, sent letters to the
26 [U.S. House](#) and [U.S. Senate](#) asking for oversight hearings on the care provided to families in DHS-
27 run detention facilities. In the letter the AMA urged Congress to hold oversight hearings with the
28 DHS and HHS on the quality of care and treatment these families are receiving.
29

30 On December 18, 2018, the AMA joined other medical associations and specialty organizations in
31 a [sign-on letter](#) strongly urging the DHS to implement specific meaningful steps to ensure that all
32 children and pregnant women in CBP custody receive appropriate medical and mental health
33 screening and necessary follow-up care by trained providers.
34

35 In July 2019, in accordance with AMA policy, the AMA [called on](#) the DHS and CBP to address the
36 conditions in their facilities at the southern border, which are inconsistent with evidence-based
37 recommendations for appropriate care and treatment of children and pregnant women. The AMA
38 also provided [a written statement](#) to the House Committee on Oversight and Reform in advance of
39 their hearings entitled, "Kids in Cages: Inhumane Treatment at the Border," and "The Trump
40 Administration's Child Separation Policy: Substantiated Allegations of Mistreatment."

1 Additionally, the AMA drafted its own [letter](#) and signed on to two letters of support ([letter 1](#) and
2 [letter 2](#)) for H.R. 3239, the “Humanitarian Standards for Individuals in Customs and Border
3 Protection Custody Act,” along with several other health care organizations. H.R. 3239 takes
4 important steps toward ensuring that appropriate medical and mental health screening and care is
5 provided to all individuals, including immigrant children and pregnant women, in CBP custody.
6

7 *Extension of Family Detention*

8

9 On September 7, 2018, DHS and HHS released a [proposed rule](#) titled, “Apprehension, Processing,
10 Care, and Custody of Alien Minors and Unaccompanied Alien Children.” In the rule, the
11 Administration proposed to expand long-term detention of migrating families. In accordance with
12 AMA policy, the AMA submitted a [comment letter](#) opposing the proposed rule.
13

14 On August 21, 2019, the [final rule](#) was released. The final rule, as did the proposed rule, seeks to
15 dismantle the Flores Settlement Agreement (FSA), a decades-old court settlement put in place to
16 ensure the safety and proper care of children in immigration detention. The FSA set strict national
17 standards for the detention, treatment, and release of all minors (both accompanied and
18 unaccompanied minors) in immigration custody. The final rule seeks to undermine the FSA by
19 allowing minors with their parents to be detained in DHS licensed family detention facilities for the
20 entirety of their immigration proceedings.
21

22 In its comment letter the AMA voiced its concern about the proposed rule’s potential negative
23 impact on the health and well-being of immigrant children and their parents/caregivers and urged
24 the Administration to withdraw the proposed rule. The AMA went on to urge the Administration to
25 give priority to supporting families and protecting the health and well-being of the children within
26 those families.
27

28 In addition, the AMA joined the American Academy of Pediatrics (AAP) in filing an [amicus brief](#)
29 describing the impact of the final rule on the health of migrating children and their families. On
30 September 27, 2019, a federal judge [blocked](#) the final rule from being implemented.
31

32 *Deferred Action for Childhood Arrivals (DACA)*

33

34 The DACA program protects more than 700,000 undocumented immigrants brought to the U.S. as
35 children from deportation and enables them to obtain work permits since being implemented by the
36 Obama Administration. On September 5, 2017, the Trump Administration [ended the program](#), but
37 federal courts blocked that attempt. Following a brief pause, the government began accepting
38 renewal applications from DACA participants. Over the years, and especially since 2017, the AMA
39 has strongly advocated on behalf of the DACA program in accordance with existing AMA policy.
40

41 In 2017, the AMA sent a [letter](#) to Congressional Leaders voicing support for S. 128, the “Bar
42 Removal of Individuals who Dream and Grow our Economy Act” (BRIDGE Act), which would
43 provide employment authorization and temporary relief from deportation for undocumented young
44 immigrants who have DACA status and DACA-eligible individuals. The AMA also [wrote](#)
45 Congress urging prompt action to protect and provide stability for individuals with DACA status.
46 Additionally in 2017, the AMA [asked](#) Congress to pass the “Development, Relief, and Education
47 for Alien Minors (DREAM) Act of 2017” (S. 1615), which would offer a bicameral, bipartisan
48 solution for the undocumented children and young adults who have been protected under the
49 DACA program. Most recently, in July 2019, the AMA, along with approximately 70 other health
50 care organizations, voiced our [support](#) for the American Dream and Promise Act of 2019 (H.R.6)
51 and the Sens. Graham/Durbin sponsored Dream Act of 2019 (S.874). The AMA worked with the

1 Association of American Medical Colleges (AAMC) to file an [amicus brief](#) with the U.S. Supreme
2 Court related to the impact of changes in DACA policy on physicians. The U.S. Supreme Court
3 will hear arguments on November 12, 2019.

4
5 *Vaccinations*
6

7 In September 2019, the AMA [wrote](#) the Administration expressing deep concern that asylum
8 seekers and other immigrants detained by CBP were not given appropriate medical care, including
9 preventive vaccinations. The letter strongly urges the Administration to allow asylum-seekers to
10 receive all medically-appropriate care, including vaccinations, in a patient-centered, language, and
11 culturally-appropriate way upon presentation for asylum regardless of country of origin.
12

13 *Mental Health of Unaccompanied Children in HHS Custody*
14

15 On September 18, 2019, the AMA submitted a [letter](#) to the U.S. House Committee on
16 Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related
17 Agencies regarding the hearing entitled, “Oversight Hearing: Mental Health Needs of Children in
18 HHS Custody.” Specifically, the AMA voiced our concern that with the opening of additional HHS
19 Office of Refugee Resettlement (ORR) shelters, immigrant minor children, in the custody of ORR
20 could be administered psychotropic drugs despite the lack of evaluation by appropriate medical
21 personnel, and potentially without parental or guardian consent or court order when the child is in
22 no imminent danger to self or others, in violation of applicable laws. In that same letter the AMA
23 also opposed the use of psychological records and social worker case files in immigration cases. A
24 copy of the letter was also sent to the Administration.
25

26 *Non-Military Deferred Action Requests*
27

28 On September 6, 2019, the AMA sent a [letter](#) urging the DHS/U.S. Citizenship and Immigration
29 Services (USCIS) to reverse its August 7, 2019 policy change that revoked its acceptance and
30 adjudication of non-military deferred action requests at field offices. The AMA argued that this
31 change in policy needlessly endangers vulnerable children and families who are seeking medical
32 deferments from deportation due to serious illnesses or the need to receive life-saving medical
33 treatments in the U.S.
34

35 USCIS has historically used deferred action, a form of prosecutorial discretion, to “provide limited
36 relief to foreign nationals who do not qualify for other immigration benefits that are typically
37 available to individuals in exigent circumstances.”² In recent years, this USCIS process has been
38 used to account for the special circumstances of individuals suffering serious medical conditions.
39 Medical deferred action in particular uses prosecutorial discretion to appropriately allow for USCIS
40 to defer and deprioritize the deportation of an individual present in the U.S. while receiving
41 medical treatment.³ The AMA argued in its letter that the discontinuation of medical deferred
42 action will lead to the termination of needed care for vulnerable patients.
43

44 On September 11, 2019, the House Committee on Oversight and Reform held a hearing titled, “The
45 Administration’s Apparent Revocation of Medical Deferred Action for Critically Ill Children.” The
46 AMA submitted a copy of our September 6 letter to the Committee. On September 19, 2019, due to
47 overwhelming public pressure, the Administration [reversed](#) its policy.

Public Charge

U.S. Department of Homeland Security Rule

On Saturday, September 22, 2018, DHS posted an unofficial draft Notice of Proposed Rulemaking (NPRM) regarding the Inadmissibility on Public Charge Grounds, and the AMA quickly responded with a [press statement](#) in opposition. On October 10, 2018, the Administration released its formal proposed rule regarding the Inadmissibility on Public Charge Grounds. The proposal denies entry or permanent legal status for noncitizens who may receive one or more public benefits including, for the first time, non-emergency Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and several public housing programs. Consistent with AMA policy adopted during the 2018 Annual Meeting, the AMA submitted a [comment letter](#) in opposition of the proposed rule. The Administration published its [final rule](#) on August 14, 2019.

On October 11, 2019, judges in separate cases before the U.S. District Courts for the Southern District of New York (SDNY) and Eastern District of Washington preliminarily enjoined the DHS from implementing and enforcing the final rule related to the public charge ground of inadmissibility. The public charge rule has already had a chilling effect, leading many immigrant families to avoid accessing vital health, nutrition and housing programs. The AMA joined with other health care organizations in submitting amicus briefs (SDNY: [amicus 1](#) and [amicus 2](#); Wash.: [amicus](#)) in the separate cases. The DHS' final rule was slated to take effect on October 15, 2019, but two of the injunctions are nationwide and prevent the DHS from implementing the rule anywhere in the U.S. until there is final resolution in the cases. Linked [here](#) is a brief overview of the public charge test.

U.S. Department of State Rule

On October 11, 2019, the U.S. Department of State (DoS) issued an [interim final rule](#) updating its definition of public charge to align its procedures with DHS' public charge final rule. On October 24, 2019, the DoS published a request for public comment on the [form DS-5540](#) or the public charge questionnaire. The DoS proposes to use the public charge questionnaire "to collect more detailed information on a visa applicant's ability to support himself or herself. Consular officers will use the information to assess whether the applicant is likely to become a public charge [at any time], based on the totality of the circumstances." On October 30, 2019, the DoS issued a "Notice of Information Collection Under OMB Emergency Review: Immigrant Health Insurance Coverage." The DoS gave the public approximately 48-hours to comment on the collection of information included in the emergency notice regarding the DoS' ability to collect information from visa applicants regarding the Presidential Proclamation (see more on the Presidential Proclamation below). As a result, the AMA submitted a [comment letter](#) to the DoS opposing the interim final rule, the expansion of the public charge questionnaire, and the information collection request related to the Presidential Proclamation.

U.S. Department of Justice Rule

The U.S. Department of Justice (DOJ), which oversees immigration courts and the Board of Immigration Appeals, is expected to publish a proposed rule that addresses the public charge deportability ground based on the DHS' public charge final rule. The DOJ rule could potentially make it easier for the Administration to deport legal immigrants who use certain public benefits such as Medicaid. Once publicly released, the AMA will review the proposal to determine if a comment letter is warranted.

1 *Presidential Proclamation*

2
3 On October 4, 2019, the President issued a [Proclamation](#) that, beginning November 3, 2019, the
4 U.S. would restrict legal immigration into this country by people who are uninsured and cannot pay
5 the costs of their health care. It is our understanding that this restriction, would operate
6 independently of the “public charge” determination. The AMA is extremely concerned about the
7 proclamation’s potential negative impact on individuals and families, who are legally immigrating
8 to the U.S., to access health care services. The AMA submitted a [letter](#) to the President of the
9 United States strongly urging him to rescind the proclamation. Linked here is a [brief overview](#) of
10 the proclamation.

11
12 On November 2, 2019, a federal judge in Oregon blocked the Presidential Proclamation from
13 taking effect for up to 28 days. The civil rights organizations behind the initial lawsuit must
14 file, by November 8, 2019, a request to block the proclamation for a longer time period, while
15 litigation continues.

REFERENCES

¹ If a parent traveling with their child was accepted for prosecution by DOJ under Zero Tolerance, and thus, transferred to U.S. Marshals Service custody, the child could not remain with the parent during criminal proceedings and the service of any potential sentence upon conviction. That child would then be placed in the care of the HHS Office of Refugee Resettlement (ORR) to arrange for safe, longer-term placement of the child pending immigration proceedings.

² <https://www.dhs.gov/xlibrary/assets/cisomb-combined-dar.pdf>

³ Id.

RELEVANT POLICY

Policy H-350.955, “Care of Women and Children in Family Immigration Detention”

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven. 2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States. 3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven. 4. Our AMA will advocate for access to health care for women and children in immigration detention.

Res. 002, A-17

Policy H-440.818, “Separation of Children From Their Caregivers at Border”

Our AMA will: (1) oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child’s well-being; and (2) urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families.

Res. 253, A-18

Policy D-65.992, “Medical Needs of Unaccompanied, Undocumented Immigrant Children”

1. Our AMA will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue. 2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.

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

Res. 5, I-15

Policy D-350.983, “Improving Medical Care in Immigrant Detention Centers”

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

Res. 017, A-17

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

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

Res. 8, I-14

Policy D-440.985, “Health Care Payment for Undocumented Persons”

Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

Res. 148, A-02 Reaffirmation A-07 Reaffirmed: CMS Rep. 01, A-17 Reaffirmation: A-19

Policy H-60.906, “Opposing the Detention of Migrant Children”

Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.

Res. 004, I-18

Policy H-420.957, “Shackling of Pregnant Women in Labor”

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents: An immediate and serious threat of harm to herself, staff or others; or A substantial flight risk and cannot be reasonably contained by other means. If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used." 2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.

Res. 203, A-10

Policy D-350.986, “Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages”

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates. 2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

Res. 305, A-15 Appended: Late Res. 1001, I-16 Reaffirmation: A-19

Policy H-350.957, “Addressing Immigrant Health Disparities”

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. 2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. 3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Res. 804, I-09 Appended: Res. 409, A-15 Reaffirmation: A-19 Appended: Res. 423, A-19

Policy H-60.905, “Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children”

1. Our AMA objects to policies separating undocumented, immigrant parents or guardians from children. 2. Our AMA only supports the practice of administering psychotropic drugs to immigrant children when there has been evaluation by appropriate medical personnel, and with parental or guardian consent or court order except in the case of imminent danger to self or others. 3. Our AMA (a) supports education for immigration

officials regarding increased risk of sexual assault and sexual trauma amongst unaccompanied minor immigrant children, as well as the emotional decompensation in this immigrant population due to these abuses and other traumas, and (b) encourages policies designed to decrease incidence of sexual assault, increase reporting and timely access to treatment services, and decrease stress and emotional trauma.
Res. 003, I-18

Policy D-440.927, “Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services”

Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.
Res. 254, A-18

Policy H-160.956, “Federal Funding for Safety Net Care for Undocumented Aliens”

Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.

Sub. Res. 207, A-93 Reaffirmed BOT Rep. 17 - I-94 Reaffirmed by Ref. Cmt. B, A-96 Reaffirmation A-02 Reaffirmation A-07 Reaffirmed: BOT Rep. 22, A-17 Reaffirmation: A-19

Policy D-60.966, “Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents”

Our AMA: (1) supports that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported; and (2) will work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation.

Res. 016, A-17

Policy H-290.983, “Support of Health Care to Legal Immigrants”

Our AMA opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations.

Res. 211, A-97 Reaffirmation A-02 Reaffirmed: BOT Rep. 19, A-12

Policy H-440.903, “Public Health Care Benefits”

Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all legal immigrants.

Res. 219, A-98 Reaffirmation A-02 Reaffirmed: BOT Rep. 19, A-12

Policy H-315.966, “Patient and Physician Rights Regarding Immigration Status”

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Res. 018, A-17

Policy H-440.876, “Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients”

1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Res. 920, I-06 Reaffirmed and Appended: Res. 140, A-07 Modified: CCB/CLRPD Rep. 2, A-14

Policy H-130.967, “Action Regarding Illegal Aliens”

Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available.

BOT Rep. MM, A-89 Reaffirmed by BOT Rep. 17 - I-94 Reaffirmed by Ref. Cmt. B, A-96 Reaffirmation A-02 Reaffirmation A-07 Reaffirmed: BOT Rep. 22, A-17

Policy H-270.961, “Medical Care Must Stay Confidential”

Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.

Res. 214, A-04 Reaffirmed: CEJA Rep. 8, A-14

H-20.901, “HIV, Immigration, and Travel Restrictions”

Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non-immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

CSA Rep. 4, A-03 Modified: Res. 2, I-10 Modified: Res. 254, A-18

H-160.920, “Financial Impact of Immigration on the American Health System”

Our AMA supports legislative and regulatory changes to require the federal government to make reasonable payments to physicians for the federally mandated care they provide to patients, regardless of the immigration status of the patient.

CMS Rep. 3, A-07 Reaffirmed: CMS Rep. 01, A-17

D-160.921, “Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare”

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

Res. 232, I-17

D-255.980, “Impact of Immigration Barriers on the Nation's Health”

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.

2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.

5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19

H-65.958, “Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court”

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent.

Res. 013, A-19

H-350.975, “Improving Healthcare of Hispanic Populations in the United States”

It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community.

(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community.

(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies.

(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization.

(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics.

(6) Promote research into effectiveness of Hispanic health education methods.

(7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border.

CLRPD Rep. 3, I-98 Reaffirmed: CLRPD Rep. 1, A-08

D-160.988, “Financial Impact of Immigration on American Health System”

Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.

Res. 235, A-06 Reaffirmation I-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Lewis Biben, MD

Introduced by the District of Columbia

Whereas, Lewis H. Biben, MD, an internal medicine physician who practiced in the Washington, DC, area, passed away on October 20, 2019; and

Whereas, Dr. Biben graduated from the University of Rochester at age 15 and Hahnemann Medical College at age 21; and

Whereas, Dr. Biben served as a Congressional Page in the 78th Congress during his high school years; and

Whereas, Dr. Biben served as the President of the Medical Society of DC (MSDC), Chairman of the Board for MSDC, and a delegate to the American Medical Association; and

Whereas, Dr. Biben was known for his love of medicine and mentorship of young physicians in the DC area; and

Whereas, Dr. Biben retired from military service as a captain in the United States Air Force in 1953; and

Whereas, Dr. Biben was married to his wife Beverly for 65 years, who herself was a leader in the MSDC Alliance; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Dr. Lewis Biben's outstanding service to the profession; and be it further

RESOLVED, That a copy of this resolution be recorded in the proceedings of this House and be forwarded to his family with an expression of the House's deepest sympathy.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Michael M. Deren, MD

Introduced by Connecticut

Whereas, Family, friends, and colleagues were deeply saddened by the passing of Michael M. Deren, MD, on July 28, 2019; and

Whereas, Dr. Deren dedicated his life to the profession of medicine; and

Whereas, Dr. Deren was an esteemed cardiothoracic surgeon in New London, Connecticut, where he was in private practice for over 30 years and was Chief of Surgery at Lawrence and Memorial Hospital for 23 years; and

Whereas, Dr. Deren was dedicated to organized medicine serving as Past-President of the New London County Medical Association and of the Connecticut State Medical Society; fellow of the American College of Surgeons; and Past-Secretary and Treasurer of the Connecticut Chapter of the American College of Surgeons; and

Whereas, Dr. Deren was passionate about his service to the AMA, serving as an Alternate Delegate from Connecticut from 2000 till 2002 and Delegate from 2002 until the time of his death. He also served on the AMA Council on Constitution and Bylaws and the Governing Council of the Organized Medical Staff Section; chaired the Connecticut Delegation to the AMA; and headed the New England Delegation to the AMA; and

Whereas, Dr. Deren was also committed to his community serving as Past-President of the White Mass for the Diocese of Norwich; he was honored as a Knight in the Order of Malta-American Association; active member of the Board of Directors of the Connecticut Lyric Opera; a member of the New London Maritime Society; and served as a volunteer tutor for immigrant students in his area; and

Whereas, Above all, Dr. Deren relished spending time with his loving wife, Anne Marie Deren; and

Whereas, Dr. Deren's passing is a tremendous loss to his patients, his family, the medical community, and organized medicine; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the tremendous contributions made by Michael M. Deren, MD, to the medical profession and organized medicine through his advocacy and commitment to his patients and to the medical community; and be it further

RESOLVED, That the AMA House of Delegates express its condolences and sympathy to the family of Michael M. Deren, MD, and present them with a copy of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Palma E. Formica, MD

Introduced by the Medical Society of New Jersey

Whereas, Palma E. Formica, MD, First Woman President of the Medical Society of New Jersey and second woman on our American Medical Association Board of Trustees; and

Whereas, Our almighty Father has called to Him, our beloved friend and colleague, Palma E. Formica, MD; and

Whereas, As a fellow and officer, Doctor Formica provided distinguished leadership to the physicians of New Jersey and singular service to the people of New Jersey; especially when it involved physician and healthcare issues on the local, state, and national levels; and

Whereas, Doctor Formica was always a very strong supporter of organized medicine, being a long time member of the Medical Society of New Jersey, serving as its first woman President; also serving as the first woman president of the Middlesex County Medical Society, and the second woman to serve on the American Medical Association Board of Trustees. Doctor Formica was recognized as a physician leader advocating for equal rights for women in medicine, in community affairs and in all fields of endeavor; therefore be it

RESOLVED, That our American Medical Association express its profound grief at the passing of Doctor Formica and extend its heartfelt sympathy to her beloved family; and be it further

RESOLVED, That this resolution be entered into the minutes of this meeting in remembrance of Palma E. Formica, MD.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Donald Theodore Lewers, MD

Introduced by Maryland

Whereas, On October 6, 2019, MedChi, The Maryland State Medical Society and its component, The Talbot County Medical Society, lost a distinguished and inspiring member of over fifty years, Donald Theodore Lewers, MD; and

Whereas, Donald Theodore Lewers, MD, “Ted” was born on December 16, 1934 in Salisbury, Maryland; and

Whereas, After serving in the Korean War as a Medic, he graduated from the University of Maryland Medical School, Cum Laude in 1964; and

Whereas, Dr. Lewers continued his professional career at the Maryland General Hospital in Baltimore; and

Whereas, He was appointed as the First Chair of the Governor’s Commission on Kidney Disease in 1971, having been a pioneer in performing kidney transplants and the development of dialysis as treatment for Renal Disease in Maryland; and

Whereas, In 1975 Dr. Lewers moved back to Talbot County, where he had a thriving practice as an Internist specializing in Hypertension and Nephrology until 2002; and

Whereas, Due to his concern about the 1986 malpractice crisis facing physicians in Maryland, he became a respected lobbyist for MedChi, with an agenda for tort reform; and

Whereas, Dr. Lewers became the President of MedChi, The Maryland State Medical Society, in 1986, during which he focused on two issues, the eroding physician – patient relationship and alternate health care systems impacting the practice of medicine; and

Whereas, His compassion for patients led him to want to do more on a national level and he was elected to the American Medical Association Board of Trustees in 1993 and served as Chair of the Board from 1999-2000; and

Whereas, Dr. Lewers keen understanding of medical malpractice suits and their impact, led him to serve on the Board of Directors for Medical Mutual Insurance Company of Maryland, from 1996 until his retirement in 2006; and

Whereas, He had a passion for nature and conservation, volunteering with The Chesapeake Wildlife Heritage, The Waterfowl Festival, Ducks Unlimited and The University of Maryland Center for the Environment and Estuarine Studies; and

Whereas, Dr. Lewers enjoyed golf, supporting oyster restoration, fishing with is grandchildren and boating with his wife, Pat, on the local rivers in his retirement; and

Whereas, He is survived by his wife, Pat Lewers, three daughters, Debbie, Linda and Kim; along with four grandchildren, Amy, Michael, Matt and Tre; one great-grandson, Russell, his sister June Terry; and many friends, colleagues and people whose lives he touched; therefore be it

RESOLVED, That our American Medical Association adopt this resolution as an indication of the deep respect the medical community holds for Donald Theodore Lewers, MD; and be it further

RESOLVED, That this resolution be entered into the minutes of the AMA 2019 Interim Meeting as an expression of the high esteem in which Dr. Lewers is held by his colleagues.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Wally O. Montgomery, MD

Introduced by Kentucky

Whereas, Former KMA Delegation Chair to the American Medical Association Wally O. Montgomery, MD passed away on November 03, 2019; and

Whereas, Dr Montgomery was a lifelong resident of the Commonwealth of Kentucky and a passionate advocate and supporter of the medical community in Kentucky for more than 50 years; and

Whereas, Dr Montgomery served in many positions in organized medicine at the local, state and national levels, including President of the McCracken County Medical Society, Governor of the Kentucky Chapter of the American College of Surgeons, and President of the Kentucky Medical Association (KMA) from 1985-1986; and

Whereas, Dr Montgomery provided a steady surgeon's hand to KMA's legislative advocacy efforts as Chair of KMA's Committee on State Legislative Activities from 1995-2001, during which time Kentucky passed numerous patient safety laws, as well as pro-physician legislation, all of which provided great benefits to the physician/patient relationship in the Commonwealth ; and

Whereas, Dr Montgomery's expertise in advocacy also led him to serve for 24 years as a Delegate to the American Medical Association, including as Senior Delegate from Kentucky to the American Medical Association; and

Whereas, Dr Montgomery also served as Chair of the KMA Budget Committee during the Great Recession of 2008, providing a steady hand to the Association's financial and administrative efforts to chart a course of financial recovery that the KMA benefits from today; and,

Whereas, Dr Montgomery received a Presidential Citation from President Ronald Regan for his work on developing the Kentucky Physician's Care Program; and

Whereas, Dr Montgomery honorably served his country as a Colonel in the United States Army Reserve with 26 years of active service; and

Whereas, Dr Montgomery served as COSCOM Surgeon during Operation Desert Shield-Desert Storm and was Deputy Chief of Staff for Health Services 332nd Medical Brigade from 1990-1992; and

Whereas, Dr Montgomery was the recipient of the KMA's Distinguished Service Award in 1990; and

Whereas, Dr Montgomery was the recipient of the Samuel D. Gross Career of Surgery Award from the University of Louisville Department of Surgery in 2010; and

Whereas, Dr Montgomery will be remembered as a strong advocate for patients and the body of medicine having led successful advocacy efforts on numerous pieces of legislation during his tenure; and

Whereas, Dr Montgomery is survived by his wife of 60 years, Geraldine, a former two term mayor of Paducah, Kentucky and their three children: Doctor Evelyn Montgomery Jones, Doctor David Montgomery and Sarah Montgomery and five grandchildren; and

Whereas, Dr Montgomery leaves a legacy of strong leadership and generous philanthropy, along with numerous friendships with colleagues around the country and within the AMA House of Delegates; therefore be it

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Bassam H. Nasr, MD

Introduced by Michigan

Whereas, Bassam H. Nasr, MD, a physician in Gastroenterology, was born September 7, 1954, and passed away on July 16, 2019; and

Whereas, Doctor Nasr grew up in Lebanon, came to the United States to fulfill the American dream through hard work, and resided in Michigan's St. Clair County for more than 30 years; and

Whereas, Doctor Nasr was a family man, friend, philanthropist, and visionary; and

Whereas, Doctor Nasr co-founded the Physician Healthcare Network 25 years ago and served as President since its inception; and

Whereas, Doctor Nasr utilized his knowledge, compassion, and leadership attributes to bring employment opportunities and access to various areas of medicine to his community; and

Whereas, So many people's lives were impacted for the better through Doctor Nasr's care as a physician and generous contributions to organizations, including but not limited to, Blue Water Hospice, SC4, the Community Foundation, and the MSMS Foundation; and

Whereas, Doctor Nasr was a current member of the Michigan State Medical Society (MSMS) Board of Directors and held various positions during his tenure, including District Director for District 7, Finance Committee Chair, and Board Secretary. He also served on the MSMS Foundation Board, and became President in 2018; and

Whereas, Doctor Nasr served with distinction and dedication on the Michigan Delegation to the American Medical Association for nine years and, most recently, was a member of the AMA Foundation Board; and

Whereas, Doctor Nasr was a tireless physician who gave generously of his time; and

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

RESOLVED, That our American Medical Association House of Delegates recognize and honor Bassam H. Nasr, MD, for his outstanding service to the profession of medicine and the countless patients whose lives were touched by his hard work and dedication; and be it further

RESOLVED, That our AMA House of Delegates extend its deepest sympathy to the family members of Bassam H. Nasr, MD.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Joseph A. Riggs, MD

Introduced by the Medical Society of New Jersey

Whereas, Our almighty Father has called to Him, our beloved friend and colleague, Joseph A. Riggs, MD; and

Whereas, As a fellow and officer, Doctor Riggs provided distinguished leadership to the physicians of New Jersey and singular service to the people of New Jersey; especially when it involved physician and healthcare issues on the local, state, and national levels; and

Whereas, Doctor Riggs was always a very strong supporter of organized medicine, being a long time member of the Medical Society of New Jersey serving as the 199th President; Camden County Medical Society President, and served on the American Medical Association Board of Trustees. Doctor Riggs was appointed by three different New Jersey Governors as a member of the State Board of Medical Examiners and received the New Jersey Academy of Medicine Award as the Outstanding Physicians of New Jersey in 1994; therefore be it

RESOLVED, That our American Medical Association express its profound grief at the passing of Doctor Riggs and extend its heartfelt sympathy to his beloved family; and be it further

RESOLVED, That this resolution be entered into the minutes of this meeting in remembrance of Joseph Riggs, MD.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Carlos Alberto Silva, MD

Introduced by the District of Columbia

Whereas, Carlos Alberto Silva, MD, a surgeon who practiced in the District of Columbia, passed away on October 13, 2019; and

Whereas, Dr. Silva was born in Mayaguez, Puerto Rico, on November 5, 1935 and graduated from the University of Puerto Rico; and

Whereas, Dr. Silva received his medical degree from George Washington University in Washington, DC in 1960; and

Whereas, Dr. Silva served his country after completing his residency and internship as a captain in the United States Air Force; and

Whereas, Dr. Silva returned to private practice and practiced in the District for 40 years; and

Whereas, Dr. Silva served as the medical director for the George Washington University Hospital; and

Whereas, Dr. Silva served as the President of the Medical Society of DC (MSDC) in 1987 and served in the AMA House of Delegates for over 25 years; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Dr. Carlos A. Silva's outstanding service to the profession; and be it further

RESOLVED, That a copy of this resolution be recorded in the proceedings of this House and be forwarded to his family with an expression of the House's deepest sympathy.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Jack Perry Strong, MD

Introduced by College of American Pathologists, American Society for Clinical Pathology, American Society of Cytopathology, United States and Canadian Academy of Pathology, National Association of Medical Examiners

Whereas, Dr. Jack Perry Strong, an esteemed member of the Pathology Section Council and American Medical Association, passed away peacefully at his home on October 19, 2019; and

Whereas, He earned his Bachelor of Science degree in 1948, from The University of Alabama with Phi Beta Kappa honors, where he was also a member of Sigma Chi fraternity; and

Whereas, He received his Doctor of Medicine degree from LSU School of Medicine in 1951, with Alpha Omega Alpha honors; and

Whereas, Dr. Strong joined the faculty of LSU Medical Center in 1955, as an instructor of pathology, became assistant professor in 1957, associate professor in 1960, full professor in 1964, and served as head of the department from 1966 until 2010. Dr. Strong retired in 2013, at the age of 83; and

Whereas, Dr. Strong was an internationally known pathologist, and the world's first person to conclusively document the relationship of smoking to atherosclerosis; and

Whereas, As the first Boyd Professor for LSU Health and Sciences Center, Dr. Strong earned the highest professorial rank within the LSU University System which is awarded to faculty scholar-researchers who have attained singular international recognition in their academic disciplines; and

Whereas, His work has influenced countless medical students, residents and graduate students; and

Whereas, Dr. Strong was Director of Laboratories at LSU Medical Center Health Care Services Division since 1998, and Director of Pathology Department at Charity Hospital in New Orleans from 1975 until his retirement; and

Whereas, He authored or co-authored more than 400 publications in his specialty field; and

Whereas, Dr. Strong received numerous scientific awards including: The Alton Ochsner Award relating smoking and cardiovascular disease (1991), International Academy of Pathology Gold Medal (1997), American Medical Association Distinguished Service Award (1998), Spirit of Charity Award (2001), The John P. McGovern Compleat Physician Award (2004), Association of Pathology Chairs Distinguished Service Award (2005), and United States and Canadian Academy of Pathology President's Award (2008). Dr. Strong received the Order of the Rising Sun, Gold Rays with Neck Ribbon, from the Emperor of Japan for his research and collaboration with Pathologists in Japan in 2008; and

Whereas, He honorably served in the United States Air Force as Captain, Res AF, from 1953 until 1955; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions made by Dr. Jack Perry Strong to the medical profession; and be it further

RESOLVED, That our AMA House of Delegates express its sympathy for the death of Dr. Strong to his family and present them with a copy of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Boyce G. Tollison, MD

Introduced by South Carolina

Whereas, Boyce G. Tollison, MD, died October 27, 2019 after a long struggle against lymphoma; and

Whereas, Dr Tollison's achievements and participation as an important, thoughtful leader in organized medicine at all levels are significant; and

Whereas, Dr. Tollison was President of the South Carolina Medical Association (2003), he was on the Board of Directors of the Southeastern Delegation to the AMA (2006 – 2017) in his role as first Alternate Delegate from South Carolina and then Delegate from South Carolina when serving as the Chair of the South Carolina Delegation to AMA; and

Whereas, Dr. Tollison served as President of the American Academy of Family Physicians (1993), Chair of the South Carolina Delegation to the AMA (2015-2017) and Chair of the Organization of State Medical Association Presidents (2014-2015); and

Whereas, In addition to all this, he found quality time for his family and church. He loved the regular hunting and fishing trips with his sons, talking about the trips with pleasure both long before and after; and

Whereas, He was beloved by his patients and community as a family physician in small town Easley, South Carolina; and

Whereas, He always had a smile on his face and a twinkle in his eye. He had a certain natural gravitas of wisdom; and

Whereas, Governor Mark Sanford awarded Boyce the prestigious and coveted Order of the Palmetto (2008), the highest civilian honor from the State of South Carolina; therefore be it

RESOLVED, That our American Medical Association House of Delegates extend its deepest sympathy to Dr. Tollison's wife, Judy; three sons Michael, Brian, and Tim; mother, Evelyn Tollison; and his extended family. He will be missed.

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

17# Specialty Society Representation in the House of Delegates - Five-Year Review

CC&B Report(s)

01 Parity in our House of Delegates

02 Bylaw Consistency--Certification Authority for Societies represented in our AMA House of Delegates and Advance Certification for those Societies

03 AMA Delegate Apportionment

CEJA Report(s)

01 Competence, Self-Assessment and Self-Awareness

02 Amendment to E-1.2.2., "Disruptive Behavior by Patients"

Resolution(s)

001 Support for the Use of Psychiatric Advance Directives

002 Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training

003 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities

004 Improving Inclusiveness of Transgender Patients Within Electronic Medical Record Systems

005 Removing Sex Designation from the Public Portion of the Birth Certificate

006 Transparency Improving Informed Consent for Reproductive Health Services

007 Addressing the Racial Pay Gap in Medicine

009 Data for Specialty Society Five-Year Review

010 Ban Conversion Therapy of LGBTQ Youth

011 End Child Marriage

** Contained in Handbook Addendum*

Contained in Sunday Tote

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-I-19

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

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The Board of Trustees (BOT) has completed its review of the specialty organizations seated in
2 the House of Delegates (HOD) scheduled to submit information and materials for the 2019
3 American Medical Association (AMA) Interim Meeting in compliance with the five-year
4 review process established by the House of Delegates in Policy G-600.020, "Summary of
5 Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw
6 8.5, "Periodic Review Process."

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

13
14 The following organizations were reviewed for the 2019 Interim Meeting:

15
16 American College of Cardiology
17 American College of Chest Physicians
18 American College of Emergency Physicians
19 American College of Gastroenterology
20 American College of Nuclear Medicine
21 American Medical Group Association
22 National Association of Medical Examiners
23

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

31
32 The materials submitted indicate that: American College of Cardiology, American College of
33 Chest Physicians, American College of Emergency Physicians, American College of
34 Gastroenterology, American College of Nuclear Medicine, American Medical Group
35 Association and the National Association of Medical Examiners are in compliance with all
36 requirements for representation in the HOD.

1 Review of the materials submitted by the American Medical Group Association (AMGA),
2 indicates that AMGA should be reclassified as a Professional Interest Medical Association
3 (PIMA). Specifically, AMGA does not represent a field of medicine that is scientifically valid,
4 but rather a practice setting. PIMAs are organizations that relate to physicians along dimensions
5 that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations
6 nor specialty societies. AMGA demonstrates that it represents and serves a professional interest
7 of physicians that is relevant to our AMA's purpose and vision and that the organization has a
8 multifaceted agenda in accordance with PIMA requirements (Exhibit E).

9
10 **RECOMMENDATIONS**

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

- 14
15 1. That the American College of Cardiology, American College of Chest Physicians,
16 American College of Emergency Physicians, American College of
17 Gastroenterology, American College of Nuclear Medicine, American Medical
18 Group Association and the National Association of Medical Examiners retain
19 representation in the American Medical Association House of Delegates. (Directive
20 to Take Action)
21
22 2. That the American Medical Group Association be reclassified as a Professional
23 Interest Medical Association (PIMA). (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American College of Cardiology	6,403 of 32,145 (20%)
American College of Chest Physicians	2,388 of 12,370 (19%)
American College of Emergency Physicians	6,980 of 31,709 (22%)
American College of Gastroenterology	1,261 of 8,709 (14%)
American College of Nuclear Medicine	49 of 169 (29%)
American Medical Group Association	4,679 of 37,249 (12%)
National Association of Medical Examiners	193 of 888 (21%)

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

Policy G-600.020

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

Exhibit C

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

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

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

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

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

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

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

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

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

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

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

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

Exhibit E - Admission of Professional Interest Medical Associations to our AMA House G-600.022

(1) Professional Interest Medical Associations (PIMAs) are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. The following guidelines will be utilized in evaluating PIMA applications for representation in our AMA House of Delegates (new applications will be considered only at Annual Meetings of the House of Delegates):

- (a) the organization must not be in conflict with the Constitution and Bylaws of our AMA;
- (b) the organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association);
- (c) the organization must meet one of the following criteria: (i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA; or (iii) that the organization was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA;
- (d) the organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application;
- (e) physicians should comprise the majority of the voting membership of the organization;
- (f) the organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office;
- (g) the organization must be active within the profession, and hold at least one meeting of its members per year;
- (h) the organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states;
- (i) the organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization; and
- (j) if international, the organization must have a US branch or chapter, and this chapter must meet the above guidelines.

(2) The process by which PIMAs seek admission to the House of Delegates includes the following steps:

- (a) a PIMA will first apply for membership in the Specialty and Service Society (SSS);
- (b) using specific criteria, SSS will evaluate the application of the PIMA and, if the organization meets the criteria, will admit the organization into SSS;
- (c) after three years of participation in SSS, a PIMA may apply for representation in our AMA House of Delegates;

(d) SSS will evaluate the application of the PIMA, determine if the association meets the criteria for representation in our AMA House of Delegates, and send its recommendation to our AMA Board of Trustees;

(e) the Board of Trustees will recommend to the House how the application of the PIMA should be handled;

(f) the House will determine whether or not to seat the PIMA; and

(g) if the application of a PIMA for a seat in the House is rejected, the association can continue to participate in SSS as long as it continues to meet the criteria for participation in SSS.

Reference Committee B

BOT Report(s)

- 01 Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
- 02 Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
- 03 Restriction on IMG Moonlighting
- 09 Opioid Mitigation
- 15# Repealing Potential Penalties Associated with MIPS Resolution; Reducing the Regulatory Burden in Health Care; Improving the Quality Payment Program and Preserving Patient Access

Resolution(s)

- 201 Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities
- 202 Support for Veterans Courts
- 203 Support Expansion of Good Samaritan Laws
- 204 AMA Position on Payment Provisions in Health Insurance Policies
- 205 Co-Pay Accumulators
- 206 Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians
- 207 Pharmaceutical Advertising in Electronic Health Record Systems
- 208 Net Neutrality and Public Health
- 209 Federal Government Regulation and Promoting Patient Access to Kidney Transplantation
- 210 Federal Government Regulation and Promoting Renal Transplantation
- 211 Effects of Net Neutrality on Public Health
- 212 Centers for Medicare and Medicaid Services Open Payments Program
- 213 Data Completeness and the House of Medicine
- 214 AMA Should Provide a Summary of its Advocacy Efforts on Surprise Medical Bills
- 215* Board Certification of Physician Assistants
- 216* Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid
- 217* Promoting Salary Transparency Among Veterans Health Administration Employed Physicians
- 218* Private Payers and Office Visit Policies
- 219* QPP and the Immediate Availability of Results in CEHRTs
- 220# Oppose Mandatory DNA Collection of Migrants
- 221# Safe Supervision of Complex Radiation Oncology Therapeutic Procedures

** Contained in Handbook Addendum*

Contained in Sunday Tote

REPORT 15 OF THE BOARD OF TRUSTEES (I-19)

Repealing Potential Penalties Associated with MIPS Resolution (206-I-18)

Reducing the Regulatory Burden in Health Care (Resolution 231-I-18)

Improving the Quality Payment Program and Preserving Patient Access (Resolution 243-A-19)

(Reference Committee B)

EXECUTIVE SUMMARY

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred two resolutions, and at the 2019 Annual Meeting, a third resolution was referred, for a combined Board of Trustees (Board) Report at the 2019 Interim Meeting related to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Resolution 206-I-18, “Repealing Potential Penalties Associated with MIPS,” asks that our AMA advocate to repeal all potential penalties associated with the Merit-Based Incentive Payment System (MIPS) program. Resolution 231-I-18, “Reducing the Regulatory Burden in Health Care,” asks that our AMA work to support the repeal of the MIPS program and oppose any federal efforts to implement any pay-for-performance programs unless such programs add no significant regulatory or paperwork burdens to the practice of medicine and have been shown, by evidence-based research, to improve the quality of care for those served. Resolution 243-A-19, “Improving the Quality Payment Program and Preserving Patient Access,” and asks that our AMA strongly advocate for Congress to make participation in MIPS and alternative payment models (APMs) under the Quality Payment Program (QPP) completely voluntary, that our AMA strongly advocate for Congress to eliminate budget neutrality in MIPS and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians, and that our AMA call on the Centers for Medicare & Medicaid Services (CMS) to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so physicians and medical societies can analyze the data to advocate for additional exemptions, flexibilities, and reductions in reporting burdens, administrative hassles, and costs.

Our AMA understands that there is significant frustration with the MIPS program and continues to vigorously advocate that both CMS and Congress make needed changes. While some progress to improve MIPS has been achieved, Resolutions 206, 231, and 243 illustrate that the implementation of a new quality and payment program for physicians is a major undertaking and significant improvements to the program are still needed—there are concerns that physicians who worked diligently and achieved a top MIPS score invested more in practice improvements than they received through their resulting MIPS incentive payment; and the budget neutrality aspect of MIPS (funding positive MIPS incentive payments with penalties imposed on practices that do not score above the MIPS performance threshold) exacerbates this problem for smaller practices. In addition to urging CMS to make additional improvements to the MIPS program, our AMA joined with many state and specialty medical societies to make it a priority to advocate that Congress provide physicians with positive Medicare payment updates and extend APM payments to provide additional resources to help physicians transition to APMs. Our AMA will work with due purpose to seek positive updates as we continue to reduce MIPS burdens.

To supplement our current policy, the Board believes that our AMA should have the ability to support legislation that shifts the budget neutrality dynamic of the current MIPS program. The Board understands that eliminating the budget neutrality requirements of the MIPS program is a complex issue and that there are many ways to achieve that goal. Therefore, we offer a recommendation to support replacing or supplementing budget neutrality in a manner that provides flexibility to review and consider legislation without being so narrowly defined that we overlook an opportunity to improve the MIPS program in another way.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-I-19

Subject: Repealing Potential Penalties Associated with MIPS
Resolution (206-I-18)
Reducing the Regulatory Burden in Health Care
(Resolution 231-I-18)
Improving the Quality Payment Program and Preserving Patient Access
(Resolution 243-A-19)

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

Referred to: Reference Committee B

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred two resolutions, and at the 2019 Annual Meeting, a third resolution was referred, for a combined Board of Trustees (Board) Report at the 2019 Interim Meeting related to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The first resolution, Resolution 206-I-18, “Repealing Potential Penalties Associated with MIPS,” was introduced by the Florida Delegation and asks that:

Our American Medical Association advocate to repeal all potential penalties associated with the MIPS program.

The second resolution, Resolution 231-I-18, “Reducing the Regulatory Burden in Health Care,” was introduced by the Pennsylvania Delegation and asks that:

Our American Medical Association work to support the repeal of the Merit-Based Incentive Payment System (MIPS); and that upon repeal of MIPS, our AMA oppose any federal efforts to implement any pay-for-performance programs unless such programs add no significant regulatory or paperwork burdens to the practice of medicine and have been shown, by evidence-based research, to improve the quality of care for those served.

The third resolution, Resolution 243-A-19, “Improving the Quality Payment Program and Preserving Patient Access,” was introduced by the Texas Delegation and asks that:

Our American Medical Association strongly advocate for Congress to make participation in MIPS and alternative payment models (APMs) under the Quality Payment Program (QPP) completely voluntary, that our AMA strongly advocate for Congress to eliminate budget neutrality in MIPS and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians, and that our AMA call on the Centers for Medicare and Medicaid Services (CMS) to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so physicians and medical societies can analyze the data to advocate for additional exemptions, flexibilities, and reductions in reporting burdens, administrative hassles, and costs.

1 The reference committee heard mixed testimony on Resolutions 206, 231, and 243. Some testified
2 that MIPS should be repealed, as many practices that serve Medicare beneficiaries cannot sustain
3 additional reductions in their Medicare payments. Others testified that our AMA should continue
4 working with Congress and the Administration to ensure that all physician practices, regardless of
5 size or specialty, have the opportunity to succeed in the QPP. Also, there was significant testimony
6 that our AMA should continue advocating to simplify and improve the MIPS program and increase
7 the number and variety of APMs available to physicians.

8 9 BACKGROUND

10
11 Our AMA was supportive when Congress replaced the flawed, target-based sustainable growth rate
12 (SGR) formula with a new payment system under MACRA. Scheduled payment cuts prior to the
13 implementation of MACRA exceeded 20 percent. Those cuts would have had a devastating impact
14 on physician practices and patient access to care. Under MACRA, the SGR formula was replaced
15 with specified payment updates for 2015 through 2019, and for 2026 and beyond. MACRA also
16 created an opportunity to address problems found in existing physician reporting programs,
17 including the chance to earn incentives. In addition, the law sought to promote innovation by
18 encouraging new ways of providing care through APMs.

19
20 Our AMA worked closely with CMS and Congress on implementation of the MIPS program, and
21 AMA advocacy efforts resulted in a policy allowing physicians who reported on one measure, one
22 time, for one patient to avoid a penalty. This transition period allowed many physician practices to
23 be successful in the first performance year of MIPS, with 93 percent of eligible clinicians receiving
24 a modest positive payment adjustment and nearly three-quarters qualifying for an additional
25 exceptional performance bonus. (Notably, the exceptional performance bonus is funded at \$500
26 million annually in the MACRA statute and is not budget neutral.)

27
28 Following the first year of the MIPS program, our AMA was also successful in getting Congress to
29 make needed technical changes to MACRA in the Bipartisan Budget Act of 2018. These changes
30 helped many practices avoid penalties that they likely would otherwise have incurred under the
31 MIPS program. Specifically, our AMA worked with Congress to exclude Medicare Part B drug
32 costs from MIPS payment adjustments, as including these additional items and services created
33 significant inequities in the administration of the program. In addition, our AMA helped achieve
34 changes that allow CMS to reweight the Cost performance category to not less than 10 percent for
35 the third, fourth, and fifth years of MIPS, instead of increasing it to 30 percent as the law
36 previously required, and to set the performance threshold for three additional years instead of
37 basing it on the mean or median of previous MIPS scores.

38 39 DISCUSSION

40 41 *Ongoing AMA Advocacy Efforts*

42
43 Since the enactment of MACRA, our AMA has worked closely with both Congress and CMS to
44 promote a smooth implementation of the QPP. Despite these efforts, Resolutions 206, 231, and 243
45 illustrate that the implementation of a new quality and payment program for physicians is a major
46 undertaking and significant improvements to the program are still needed. As is noted in the
47 resolutions, there are numerous improvements that must still be made to the MIPS program,
48 including more accurate risk adjustment for cost and quality measures, timelier program feedback
49 for physicians, and a more cohesive program structure. In addition, physician practices, especially
50 small and rural physician practices, cannot shift to new payment models without adequate
51 resources.

1 In an effort to address these outstanding issues, our AMA has convened MIPS and APM
2 workgroups made up of representatives from across the physician community, which have
3 developed creative solutions to improve the QPP. Feedback from the MIPS and APM workgroups,
4 as well as other state and specialty medical societies, has led our AMA to focus its efforts to
5 improve the QPP on several key issues: replacing the upcoming Medicare physician pay freeze
6 with a stable revenue source that allows physicians to sustain their practice; eliminating budget
7 neutrality; extending the Advanced APM payments for an additional six years; simplifying the
8 MIPS scoring system and creating a more meaningful MIPS program; and ensuring small and rural
9 practices have the opportunity to succeed.

10 11 *Replace Physician Payment Freeze*

12
13 Resolution 206 notes that many physician practices cannot sustain additional reductions in their
14 Medicare payments. Our AMA agrees, and while MACRA included modest positive payment
15 updates in the Medicare Physician Fee Schedule, it left a gap from 2020 through 2025, during
16 which there are no updates at all. Following this six-year freeze, the law specifies physician
17 payment updates of 0.75 or 0.25 percent for physicians participating in APMs or MIPS.

18
19 Our AMA recognizes that these payment updates are not sufficient, particularly while physicians
20 are investing resources to improve the quality of patient care and shift to new payment models.
21 Therefore, our AMA recently testified before Congress, urging Congress to pass legislation
22 providing physicians with positive payment updates beginning in 2020. The Board strongly
23 supports advocating for positive payment updates, which are needed to provide physicians a
24 margin to maintain their practice, as well as transition to more efficient models of care delivery.

25 26 *Extend APM Payments*

27
28 In addition to providing positive physician payment updates, Congress and the Administration must
29 also work to provide physicians with adequate resources to move into new payment models. One
30 goal of MACRA, in addition to the MIPS program, was to provide physicians with a path to
31 transition into new, innovative APMs that could allow physicians to be paid for services that add
32 value to patient care.

33
34 To help facilitate this transition, Congress provided a five percent incentive payment for physicians
35 who participate in Advanced APMs during the first six years of the program. Unfortunately,
36 through the first three participation years, very few physicians had the opportunity to earn this
37 incentive payment due to the small number of Advanced APMs approved by CMS. While our
38 AMA is working closely with numerous physician groups, as well as the Center for Medicare and
39 Medicaid Innovation (CMMI), to develop and test physician-led APMs, it will take time to
40 implement the number of APMs needed to allow most physicians a realistic opportunity to
41 participate in these models. Therefore, our AMA is urging Congress to extend the Advanced APM
42 incentive payments to provide support to physicians as they transition to new payment models. The
43 Board strongly supports efforts to ensure there are voluntary APMs available for physicians in all
44 specialties and practices of all sizes.

45 46 *Impact of Budget Neutrality*

47
48 The Board strongly supports providing physicians with the resources necessary to improve quality
49 and patient care. The Board is therefore concerned about reports from numerous physicians who
50 have worked diligently to comply with the numerous MIPS requirements, yet have ended up
51 investing more in health information technology and care management processes than they

1 received through their resulting MIPS incentive payment. The negative return on investment from
2 MIPS participation is a serious problem. Also, several witnesses have testified in reference
3 committee that funding positive MIPS incentive payments with penalties imposed on practices that
4 do not score above the MIPS performance threshold exacerbates this problem for smaller practices.
5 The Board supports language in Resolution 243-A-19 noting that physicians need dedicated
6 funding for MIPS incentive payments in order to ensure physicians have the capital they need to
7 move into models that provide patients with the utmost value. Basing positive payment adjustments
8 on penalties also creates uncertainty in the program, which further discourages practices from
9 making the up-front investments needed to transition to value-based payment and care delivery
10 models.

11
12 While supporting the elimination of budget neutrality in the MIPS program, the Board also
13 understands that this is a complex issue that would involve some difficult trade-offs. It would be
14 extremely difficult to secure funding from Congress both for positive MIPS incentive payments,
15 which would help practices that participate in MIPS and exceed the MIPS performance threshold,
16 and funding for positive conversion factor updates, which would help all practices that care for fee-
17 for-service Medicare patients, including small practices that are excluded from MIPS because they
18 are below the low-volume threshold. In addition, physicians in large practices have generally
19 obtained higher MIPS scores than those in smaller practices, so this policy is more likely to help
20 large practices than smaller practices. Partially or fully eliminating MIPS budget neutrality may
21 also make it more difficult to achieve adoption of AMA recommendations to improve the MIPS
22 program, because Congress and the Administration would view any increase in the number of
23 physicians able to succeed in MIPS as increasing federal spending.

24
25 Despite these concerns, the Board determined that replacing or supplementing the budget neutrality
26 requirements in MIPS with incentive payments would help support physicians as they continue to
27 work to comply with the program. Therefore, the Board supports MIPS incentive payments not
28 limited by budget neutrality requirements to provide physicians a margin to transition into more
29 efficient models of care delivery.

30 31 *Simplifying and Streamlining MIPS*

32
33 Our AMA has repeatedly urged CMS to make MIPS more clinically relevant for physicians and
34 patients. As noted in Resolution 243, many physicians must report MIPS measures that are not
35 linked to improved clinical care for their patients. Our AMA's MIPS workgroup has developed
36 detailed recommendations that would make the MIPS program more cohesive and allow physicians
37 to select more relevant measures to report.

38
39 For example, our AMA has urged CMS to streamline the MIPS program by allowing physicians to
40 focus their participation around a specific episode of care, clinical condition, or public health
41 priority. By allowing physicians to focus on activities that fit into their workflow and address their
42 patient populations' needs, rather than segregated measures divided into four disparate MIPS
43 categories, the program would be more likely to improve quality of care for patients and be more
44 meaningful for physicians.

45
46 Our AMA has also urged Congress to allow CMS the flexibility to base scoring on multi-category
47 measures to make MIPS more clinically meaningful, reduce silos between each of the four MIPS
48 categories, and create a more unified program. Our AMA's goal is to help the administration
49 develop an approach that allows physicians to spend less time on reporting and more time with
50 patients and on improving care. The Board strongly supports the efforts to unify MIPS reporting
51 while also making it more meaningful for physicians.

Support for Small and Rural Practices

As noted in Resolution 231, our AMA agrees that small physician practices could be disproportionately impacted by penalties under MIPS. In 2017, the national mean and median scores for all MIPS eligible clinicians were 74.01 and 88.97 points. However, the mean and median scores for small practices were 43.46 and 37.67. Our AMA agrees that the lower scores achieved by small practices illustrate the need for AMA to continue advocating for changes to MACRA that will help small practices and solo practitioners.

In order to help small practices become more successful in the MIPS program, our AMA has engaged in advocacy efforts in multiple areas. First, our AMA has been a strong supporter of the low-volume threshold exemption which was increased and now excludes physicians with allowed charges of \$90,000 or less, 200 or fewer unique Medicare patients, or 200 or fewer covered professional services to Medicare Part B beneficiaries from the MIPS program. Our AMA has also supported MIPS policies including reduced reporting requirements for small practices in the Quality performance category, hardship exemptions from the Promoting Interoperability performance category for qualifying small practices, bonus points for small practices, and technical assistance grants to help small and rural practices succeed in the program. Finally, our AMA is advocating for a legislative change that would allow CMS to develop separate thresholds for small and large practices, so that small physician practices are compared to practices with similar resources. The Board agrees that additional changes are needed to ensure small and rural practices have the opportunity to succeed in the MIPS program.

Other Advocacy Efforts

In addition to these major program changes, our AMA also continues to urge CMS and Congress to address more nuanced issues in the QPP such as:

- Stabilizing the performance threshold until program improvements are tested and implemented;
- Revamping the Virtual Group option to encourage small practices to participate;
- Improving risk adjustment methodologies to account for social risk factors;
- Reducing the number of quality measures a physician must report under the Quality performance category;
- Maintaining a minimum point floor for physicians reporting on quality measures that meet the data completeness threshold, regardless of performance on the measure;
- Eliminating the requirement that physicians must report on an outcome or high priority measure and eliminating the requirement to report on all-payer data;
- Developing a phased approach for removing “topped-out” measures from MIPS and improving the benchmark methodology;
- Aligning the MIPS and Physician Compare calculation methodologies;
- Maintaining the Cost performance category weight while new episode-based cost measures are developed and piloted;
- Modifying the threshold levels of APM participation required to be eligible for the APM incentive payments;
- Securing adoption of physician-focused payment models with realistic targets for improving patient health outcomes and generating savings;
- Eliminating the Total Cost of Care and Medicare Spending Per Beneficiary measures within the Cost performance category as improved episode-based cost measures are developed;
- Allowing physicians to attest to their use of Certified Electronic Health Information Technology (CEHRT) in the Promoting Interoperability performance category;

- 1 • Reducing the number of measures physicians are required to report in the Promoting
- 2 Interoperability performance category; and
- 3 • Providing credit for the use of health information technology beyond CEHRT.

4
5 As illustrated by the list above, our AMA has spent significant staff time working with both
6 Congress and CMS to improve the QPP. Our AMA has specifically been advocating persistently
7 for MIPS to be more meaningful to physicians and less administratively burdensome, and to
8 increase the number of available APMs. Our AMA advocacy team meets regularly with both CMS
9 officials and Congressional staff to work to improve MIPS and the APM pathway for physicians
10 and will continue to do so going forward.

11
12 Among the concerns raised with seeking repeal of the MIPS penalties at this time is that the cost
13 would need to be offset and would potentially come at the expense of bonuses or across the board
14 cuts in physician payments, which would impact physicians who are currently exempt from MIPS,
15 such as small practices. Another concern is that repealing penalties associated with MIPS or
16 repealing the entire program at this time could result in an alternative quality payment program that
17 may be less desirable. Furthermore, such a shift in our AMA's advocacy position would effectively
18 preclude our AMA from continuing our advocacy efforts with state and specialty medical societies
19 in support of the Administration's and Congress' efforts to advance successful, innovative payment
20 models as well as the technologies needed to support such models.

21 22 AMA POLICY

23
24 Our AMA has numerous existing policies on MACRA including Policies D-395.999, D-395.998,
25 H-390.838, D-390.950, and D-390.949. Together, these policies direct our AMA to work with
26 CMS to advocate for improvements to MIPS, a reduction in MIPS requirements for all physicians,
27 an exemption to MIPS for small practices, a period of stability in the MIPS program to allow for
28 testing and stability and additional flexibilities for fragile practices. AMA policy also supports our
29 advocacy to increase the number and variety of APMs available to physicians, extend the
30 Advanced APM incentive payments to provide support to physicians as they transition to new
31 payment models, and modify the threshold levels of APM participation required to be eligible for
32 the APM incentive payments (Policies H-385.913, H-450.931, and H-385.908).

33 34 CONCLUSION

35
36 Our AMA understands that there is significant frustration with the MIPS program and continues to
37 vigorously advocate that both CMS and Congress make needed changes. In addition to urging
38 CMS to make additional improvements to the MIPS program, our AMA is joined with many state
39 and specialty medical societies making it a priority to advocate that Congress provide physicians
40 with positive Medicare payment updates and extend APM payments to provide physicians with
41 additional resources to help transition to APMs. The Board believes that the lack of positive
42 updates from 2020 to 2025 severely threatens physicians' ability to sustain their practices,
43 especially while at the same time implementing quality improvements. Our AMA will work with
44 due purpose to seek positive updates as we continue to reduce MIPS burdens.

45
46 While the Board recognizes that the QPP needs improvement, we also acknowledge that the MIPS
47 program is only two years old. Detailed results from the 2017 performance year were recently
48 released and CMS is still analyzing what those results mean for how practices will perform in the
49 future. Implementation of a new quality and payment program is a significant undertaking and
50 requires an iterative process with constant evaluation and improvement.

1 In addition to our current policy, the Board believes that our AMA should have the ability to
2 support legislation that could shift the budget neutrality dynamic of the current MIPS program. The
3 Board understands that eliminating the budget neutrality requirements of the MIPS program is a
4 complex issue and that there are many ways to achieve that goal. Therefore, we offer a
5 recommendation to support replacing or supplementing budget neutrality in a manner that provides
6 flexibility to review and consider legislation without being so narrowly defined that we overlook an
7 opportunity to improve the MIPS program in another way.

8
9 Therefore, the Board recommends, consistent with existing AMA policy, that our AMA continue
10 its work with CMS and Congress to improve the MIPS program, increase APM opportunities for
11 physicians, and provide additional resources for physician practices through positive updates and
12 APM payments. Given that the repeal of MACRA could result in a more burdensome quality
13 program with no opportunity to earn incentives and lower payment updates for physicians, we
14 recommend not advocating for the repeal of MIPS penalties or the MIPS program at this time.
15 However, the Board will continue to monitor the QPP's impact and burden on physicians, and if
16 improvements to the program are not sufficient, we will reevaluate our advocacy policies and
17 position in the future.

18 19 RECOMMENDATION

20
21 The Board of Trustees recommends that the following recommendations be adopted in lieu of
22 Resolutions 206-I-18, 231-I-18, and 243-A-19 and that the remainder of the report be filed:

- 23
24 1. That our American Medical Association (AMA) support legislation that replaces or
25 supplements the budget neutrality in MIPS with incentive payments.
26
27 2. That our AMA reaffirm Policy D-395.999, "Reducing MIPS Reporting Burden," Policy D-
28 395.998, "Opposed Replacement of the Merit-Based Incentive Payment System with the
29 Voluntary Value Program," Policy H-390.838, "MIPS and MACRA Exemption," Policy D-
30 390.950, "Preserving a Period of Stability in Implementation of the Medicare Access and
31 Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA)," Policy D-
32 390.949, "Preserving Patient Access to Small Practices Under MACRA," Policy H-385.913,
33 "Physician-Focused Alternative Payment Models," Policy H-385.913, "Physician-Focused
34 Alternative Payment Models," Policy H-450.931, "Moving to Alternative Payment Models,"
35 and Policy H-385.908, "Physician-Focused Alternative Payment Models: Reducing Barriers."

Fiscal Note: Less than \$500

EXISTING AMA POLICY

Policy D-395.999, “Reducing MIPS Reporting Burden”

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician’s choosing) within the calendar year.

Policy D-395.998, “Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program”

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

Policy H-390.838, “MIPS and MACRA Exemption”

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Policy D-390.950, “Preserving a Period of Stability in Implementation of the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act (MACRA)”

1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

Policy D-390.949, “Preserving Patient Access to Small Practices Under MACRA”

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.

2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Policy H-385.913, “Physician-Focused Alternative Payment Models”

1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
 - A. Be designed by physicians or with significant input and involvement by physicians;
 - B. Provide flexibility to physicians to deliver the care their patients need;
 - C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
 - D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
 - E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
 - F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
 - G. Avoid placing physician practices at substantial financial risk;
 - H. Minimize administrative burdens on physician practices; and
 - I. Be feasible for physicians in every specialty and for practices of every size to participate in.
3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
 - A. Identify leading health conditions or procedures in a practice;
 - B. Identify barriers in the current payment system;
 - C. Identify potential solutions to reduce spending through improved care;
 - D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
 - E. Define services to be covered under an APM;
 - F. Identify measures of the aspects of utilization and spending that physicians can control;
 - G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
 - H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
 - I. Identify mechanisms for ensuring adequacy of payment; and
 - J. Seek support from other physicians, physician groups, and patients.
4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
 - A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
 - B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
 - C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
 - D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
 - E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.
5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models.

Policy H-450.931, “Moving to Alternative Payment Models”

1. As physician payment moves to pay-for-value, our American Medical Association will help physician practices with the following: (a) physician practices need support and guidance to optimize the quantity and content of physician work under alternative payment models; (b) address physicians' concerns about the operational details of alternative payment models to improve their effectiveness; (c) to succeed in alternative payment models, physician practices need data and resources for data management and analysis; and (d) harmonize key components of alternative payment models across multiple payers, especially performance measures to help physician practices respond constructively.
2. Our AMA will, in partnership with other appropriate physician organizations, work with the Centers for Medicare & Medicaid Services to establish an appropriate timetable for implementation of pay-for-value models that takes into account the physician community's readiness to assume two-sided risk (up-side and down-side risk).

Policy H-385.908, “Physician-Focused Alternative Payment Models: Reducing Barriers”

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.
3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
 - a. Continue to expand technical assistance;
 - b. Develop IT systems that support and streamline clinical participation;
 - c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;
 - d. Identify methods to reduce the data collection burden; and
 - e. Begin implementing the 21st Century Cures Act.
5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:
 - a. 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 socio-demographic factors;
 - b. 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; and
 - c. 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.
6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
 - a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;
 - b. Distinguish between services ordered by a physician and those delivered by a physician;
 - c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even

having a contract that articulates the patient's and physician's responsibility for managing the condition; and

e. Provide physicians with lists of attributed patients to improve care coordination.

7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:

a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;

b. Account for costs that are not currently billable but that cost the practice to provide; and

c. Account for lost revenue for providing fewer or less expensive services.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-19)

Introduced by: Medical Student Section

Subject: Oppose Mandatory DNA Collection of Migrants

Referred to: Reference Committee B

1 Whereas, The Department of Justice has amended a regulation that would mandate DNA
2 collection for a majority of migrants who cross between official entry points by “striking” a
3 provision authorizing the Secretary of Homeland Security to exempt from the sample-collection
4 requirement certain aliens from whom collection of DNA samples is not feasible”;¹ and
5

6 Whereas, DNA collection has traditionally been used for those under criminal investigation;² and
7

8 Whereas, Previous long-standing policy was to collect DNA from migrants only being
9 prosecuted in federal courts on criminal charges;² and
10

11 Whereas, Part of the argument for expanding DNA databases is to preserve safety; however,
12 this argument is not aligned with current evidence given undocumented immigrants are less
13 likely to commit violent crime than US citizens and undocumented immigrants are less likely to
14 be perpetrators of DUI arrests, drug arrests, drug overdose deaths;³⁻⁵ and
15

16 Whereas, Neither the number of undocumented immigrants in a city nor sanctuary status of a
17 city affects the crime rate;^{6,7} and
18

19 Whereas, The American Civil Liberties Union opposes the expansion of state DNA databases
20 which aim to include those who have been arrested but not yet convicted, raising “privacy and
21 civil liberties concerns” that the “[amended] rule changes the purpose of DNA collection from
22 criminal investigation to surveillance of the population”;^{8,9} and
23

24 Whereas, The United Nations Special Rapporteur on the right to privacy has stated explicitly
25 that “DNA databases raise human rights concerns, including potential misuse of government
26 surveillance”;¹⁰ and
27

28 Whereas, The Grand Chamber of the European Court of Human Rights outlawed the collection
29 and indefinite retention of DNA profiles, noting that it was a violation of the right to personal
30 privacy;¹¹ and
31

32 Whereas, The AMA Code of Medical Ethics (IV) states that “A physician shall respect the rights
33 of patients, colleagues, and other health professionals, and shall safeguard patient confidences
34 and privacy within the constraints of the law”;¹² and
35

36 Whereas, H-65.958 states that our AMA already condemns the use of confidential medical and
37 psychological records and social work case files as evidence in immigration courts without
38 patient consent; and

Whereas, Per AMA policy (H-315.983, point 7), DNA is confidential medical information, the use of which should require consent; and

Whereas, Our AMA believes that individuals have the right to informed consent when their DNA is used as part of a research databank and to make decisions about how their information is used, underlining the fundamental right to privacy we believe individuals should have regarding their biological information (*AMA Code of Ethics 7.3.7*); and

Whereas, AMA policy (H-80.995) states DNA testing of individuals for information in criminal cases should be conducted only where a warrant has been issued on the basis of a high degree of individualized suspicion; and

Whereas, The Department of Justice proposed ruling would allow for DNA collection of immigrants without a warrant; therefore be it

RESOLVED, That our American Medical Association oppose the collection and storage of the DNA of refugees, asylum seekers, and undocumented immigrants for nonviolent immigration-related crimes without non-coercive informed consent. (New HOD Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 11/16/19

RELEVANT AMA POLICY

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. (Res. 013, A-19)

Evaluation of the Use of DNA Identification Testing in Criminal Proceedings H-80.995

(1) A national standard for uniform quality control guidelines should be developed which would govern: (a) appropriate control procedures to minimize the adverse effects of contamination and degradation; (c) an objective standard for identifying separate DNA bands and declaring a match between two or more DNA samples; and (c) the creation and use of population databases which accurately reflect the ethnic composition of populations amongst which matches might be sought.

(2) The independent validation of each probe used for DNA identification testing should be conducted.

(3) Further research is needed to determine the effects of contamination and degradation on forensic samples.

(4) DNA testing of individuals for information in criminal cases should be conducted only where a warrant has been issued on the basis of a high degree of individualized suspicion. Maintaining the files of any individual who is no longer a suspect in a particular crime raises serious concerns regarding potential violations of privacy. Therefore it may not be appropriate to retain such files. (BOT Rep. FF, I-91, Reaffirmed: Sunset Report, I-01, Modified: CSAPH Rep. 1, A-11)

7.3.7 Safeguards in the Use of DNA Databanks

DNA databanks facilitate population-based research into the genetic components of complex diseases. These databanks derive their power from integrating genetic and clinical data, as well as data on health, lifestyle, and environment about large samples of individuals. However, the use of DNA databanks in genomic research also raises the possibility of harm to individual participants, their families, and even populations.

Breach of confidentiality of information contained in DNA databanks may result in discrimination or stigmatization and may carry implications for important personal choices, such as reproductive choices.

Human participants who contribute to research involving DNA databanks have a right to be informed about the nature and scope of the research and to make decisions about how their information may be used.

In addition to having adequate training to be able to discuss genomic research and related ethical issues with patients or prospective research participants, physician-researchers who are involved in genomic research using DNA databanks should:

Research involving individuals

(a) Obtain informed consent from participants in genomic research, in keeping with ethics guidance. In addition, physicians should put special emphasis in the consent process on disclosing:

(i) the specific privacy standards to which the study will adhere, including whether the information or biological sample will be encrypted and remain identifiable to the researcher or will be completely de-identified;

(ii) whether participants whose data will be encrypted rather than de-identified can expect to be contacted in the future about findings or be invited to participate in additional research, either related to the current protocol or for other research purposes;

(iii) whether researchers or participants stand to gain financially from research findings, and any conflicts of interest researchers may have in regard to the research, in keeping with ethics guidance;

(iv) when, if ever, archived information or samples will be discarded;

(v) participants' freedom to refuse use of their biological materials without penalty.

Research involving identifiable communities

(b) When research is to be conducted within a defined subset of the general population, physicians should:

(i) consult with the community in advance to design a study that is sensitive to community concerns and that will minimize harm for the community, as well as for individual participants. Physicians should not carry out a study when there is substantial opposition to the research within the community of interest;

(ii) protect confidentiality by encrypting any demographic or identifying information that is not required for the study's purpose. (Issued: 2016)

4.1.4 Forensic Genetics

With the exception of genetic information (or material) collected under the jurisdiction of a coroner, medical examiner, or other medical legal officer, the release of genetic information from a physician's records without the patient's informed consent constitutes a breach of confidentiality. However, under limited circumstances with overriding legal and social considerations, all physicians may disclose such information to the criminal justice system.

Physicians from whom genetic information is sought for purposes of criminal justice:

(a) May ethically carry out DNA analysis on stored tissue samples or release genetic information without the consent of a living or deceased patient (or the patient's authorized surrogate) in response to a warrant or court order.

(b) Should release only the minimum information necessary for the specific purpose.

(c) Should not be required to provide genetic information when:

(i) a suspect whose location is known refuses to provide a tissue sample for genetic analysis; or

(ii) a tissue sample for the suspect can be obtained from other sources (such as the body of a deceased suspect).

(d) Should decline to participate in the use of information from a genetic database created exclusively for criminal justice for any purpose other than identification. (Issued: 2016)

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for

policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. (Res. 804, I-09, Appended: Res. 409, A-15, Reaffirmation: A-19, Appended: Res. 423, A-19)

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non-immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. (CSA Rep. 4, A-03, Modified: Res 2, I-10, Modified: Res. 254, A-18)

Biometric Technologies Used to Enhance Security H-478.989

Our AMA encourages the use of biometric technologies where feasible, such as, but not limited to, fingerprint and palm scanners in hospitals and clinics (1) for patient identification to improve patient safety while reducing health insurance fraud and (2) for providers to streamline and secure user authentication processes and better protect patient privacy. (Res. 816, I-11)

References:

1. US Department of Justice. DNA-sample collection from immigration detainees (Proposed Rule). 28 CFR Part 28. *Federal Register*. Vol. 84, No. 204: 56397-56401. <https://www.govinfo.gov/content/pkg/FR-2019-10-22/pdf/2019-22877.pdf> Published Oct 22 2019. Accessed Nov 11 2019.
2. Cornell Law School Legal Information Institute. 28 CFR § 28.12 - Collection of DNA samples. <https://www.law.cornell.edu/cfr/text/28/28.12> Accessed Nov 11 2019.
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12. American Medical Association. AMA principles of medical ethics. *AMA Code of Ethics*. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf> Revised June 2001. Access Nov 11 2019

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-19)

Introduced by: Resident and Fellow Section

Subject: Safe Supervision of Complex Radiation Oncology Therapeutic Procedures

Referred to: Reference Committee B

Whereas, Radiation therapy is a complex medical procedure that is directly supervised by physicians trained in radiation oncology; and^{1,2,3,4}

Whereas, The American College of Radiology, the American Society for Radiation Oncology, the American College of Radiation Oncology, the US Nuclear Regulatory Commission, and other organizations consider supervision of radiation oncology services by a radiation oncologist as critical to the safe delivery of radiation oncology services; and

Whereas, Radiation therapy often involves treating patients with doses of radiation that can be fatal if not delivered with proper quality assurance systems in place; and

Whereas, Physician review of toxicity from treatment, daily patient setup variability, real time imaging interpretation for accurate radiation guidance, and other clinical parameters are often required during radiation treatment and can lead to adaptive changes in radiation treatment or giving treatment breaks when further treatment is deemed unsafe; and^{5,6}

Whereas, The Centers for Medicare and Medicaid Services Hospital Outpatient Prospective Payment System (HOPPS) final rule included a provision to change supervision of HOPPS therapeutic services from direct supervision to “general supervision”; and⁷

Whereas, General supervision, according to Medicare, “means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure”; and⁷

Whereas, Loosening requirements for supervision will increase the use of non-physician supervision of radiation therapy services; and

Whereas, Physicians are the only healthcare providers trained in radiation treatment and patient management, and non-physician healthcare providers do not have any training in this scope of practice; and

Whereas, Loosening supervision requirements for radiation oncology therapeutic services could lead to the provision of unsafe treatment of patients with cancer; therefore be it⁸

RESOLVED, That our American Medical Association advocate that radiation therapy services should be exempted from the Hospital Outpatient Prospective Payment System (HOPPS) rule requiring only general supervision of hospital therapeutic services (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA advocate that direct supervision of radiation therapy services by a
- 2 physician trained in radiation oncology should be required by the Centers for Medicare and
- 3 Medicaid Services. (Directive to Take Action)

Received: 11/16/19

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

References:

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2. ACR Radiation Oncology Practice Accreditation Program Requirements, <https://www.acraccreditation.org/~media/ACRAccreditation/Documents/ROPA/Requirements.pdf>
3. Conference of Radiation Control Program Directors, Part X: Therapeutic Radiation Machines, https://c.ymcdn.com/sites/www.crcpd.org/resource/resmgr/docs/SSRCRs/X_2009.pdf
4. ASTRO Guidance on Supervision of Radiation Therapy Services, https://www.astro.org/uploadedFiles/MAIN_SITE/Daily_Practice/Content_Pieces/SupervisionWhitePaper.pdf
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7. Department of Health and Human Services, Changes to HOPPS, <https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24138.pdf>
8. American Society for Radiation Oncology, 2020 Medicare rules continue stable fee schedule rates, reduce hospital supervision levels, <https://www.astro.org/News-and-Publications/What-is-Happening-in-Washington/2019/2020-Medicare-Rules-Continue-Stable-Fee-Schedule-R>

RELEVANT AMA POLICY:

Supervision Requirements for Outpatient Therapeutic Services D-390.959

Our AMA will work with key stakeholders to make general supervision, rather than direct supervision, the requirement for Medicare payment for most, but not all, outpatient therapeutic services.

Citation: (BOT action in response to referred for decision Res. 218, A-10)

Nuclear Regulatory Commission Licensure Requirements for Physicians H-455.996

Our AMA urges the U.S. Nuclear Regulatory Commission to continue to require that the training requisite for licensure be documented, and that it contain elements of instruction in radiological physics, radiation biology, radiation safety, nuclear instrumentation, and the safe and effective clinical use of radionuclides in patients.

Citation: (Res. 148, A-80; Reaffirmed: CLRPD Rep. B, I-90; Modified: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

Reference Committee C

CME Report(s)

- 02 Healthcare Finance in the Medical School Curriculum
- 03 Standardization of Medical Licensing Time Limits Across States
- 04 Board Certification Changes Impact Access to Addiction Medicine Specialists
- 06 Veterans Health Administration Funding of Graduate Medical Education

Resolution(s)

- 301 Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools
- 302 Strengthening Standards for LGBTQ Medical Education
- 303 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations
- 304 Issues with the Match, The National Residency Matching Program (NRMP)
- 305 Ensuring Access to Safe and Quality Care for our Veterans
- 306 Financial Burden of USMLE Step 2 CS on Medical Students
- 307 Implementation of Financial Education Curriculum for Medical Students and Physicians in Training
- 308 Study Expediting Entry of Qualified IMG Physicians to US Medical Practice
- 309# Follow-up on Abnormal Medical Test Findings
- 310# Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closures

** Contained in Handbook Addendum*

Contained in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(I-19)

Introduced by: Georgia

Subject: Follow-up on Abnormal Medical Test Findings

Referred to: Reference Committee C

Whereas, Failure to review radiology reports¹ or to appropriately communicate or follow up on abnormal radiologic findings is a common occurrence;^{2,3,4,5} and

Whereas, This can lead to delays in diagnosis, malpractice lawsuits⁶ and negative outcomes; and

Whereas, QI initiatives have been shown to improve the likelihood of appropriate follow up of abnormal radiologic findings;^{7,8} therefore be it

RESOLVED, That our American Medical Association advocate for the adoption of evidence-based guidelines on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes (Directive to Take Action); and be it further

RESOLVED, That our AMA work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes. (Directive to Take Action)

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

Received: 10/24/19

¹ <https://doi.org/10.1016/j.jacr.2018.08.022>

² <https://www.ajronline.org/doi/full/10.2214/AJR.18.20586>

³ <https://www.ajronline.org/doi/full/10.2214/AJR.18.20083>

⁴ *AJR Am J Roentgenol*. 2019 Mar;212(3):589-595. doi: 10.2214/AJR.18.20083. Epub 2019 Jan 8.

⁵ [https://www.jacr.org/article/S1546-1440\(14\)00591-2/abstract](https://www.jacr.org/article/S1546-1440(14)00591-2/abstract)

⁶ <https://www.degruyter.com/view/j/dx.2014.1.issue-4/dx-2014-0034/dx-2014-0034.xml?intcmp=trendmd>

⁷ <https://www.ajronline.org/doi/10.2214/AJR.17.18332>

⁸ <https://link.springer.com/article/10.1007/s10278-017-9989-y>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(I-19)

Introduced by: Resident and Fellow Section

Subject: Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure

Referred to: Reference Committee C

1 Whereas, On June 26th, 2019, Hahnemann University Hospital in Philadelphia, Pennsylvania,
2 announced that it would be filing for Chapter 11 bankruptcy and closing its residency programs
3 resulting in the displacement of 571 residents and fellows from their training programs¹; and
4

5 Whereas, The abrupt closing of Hahnemann Hospital represents the largest loss of medical
6 trainees to a community in a single event^{1,7}; and
7

8 Whereas, Another hospital, the Ohio Valley Medical Center in Wheeling, West Virginia
9 announced on August 7, 2019 that it would be closing within 60-90 days, displacing
10 approximately 32 internal medicine and emergency medicine residents²; and
11

12 Whereas, Upon closure of a Sponsoring Institution of a Graduate Medical Education (GME)
13 program, residents and fellows previously training at that institution are given no guarantee that
14 they will be able to secure another position to continue their medical education and training³;
15 and
16

17 Whereas, While the Accreditation Council for Graduate Medical Education (ACGME) policies
18 allow displaced residents to transfer to any hospital that is willing to train them in their specialty,
19 such transfer is dependent on the release of the resident or fellow's training position and
20 associated funding by the closing hospital³; and
21

22 Whereas, The ACGME's Institutional Requirements requires that Sponsoring Institutions of a
23 GME training program must maintain a policy that addresses reductions in size or closure of its
24 ACGME-accredited programs or closure of the Sponsoring Institution, though does not specify
25 any information regarding funding or a specific timeline by which residents/fellows should be
26 notified⁴; and
27

28 Whereas, In the event of closure/reduction in size of a GME program or closure Sponsoring
29 Institution, medical trainees have no legal representation in the process of re-allocation of
30 resident funding, and
31

32 Whereas, On September 5, 2019, despite the opposition of the federal government, bankruptcy
33 court Judge Kevin Gross approved the sale by auction of Hahnemann's residency slots for \$55
34 million to a six-hospital consortium Einstein Healthcare Network, Jefferson Health, Temple
35 University Health System, Main Line Health, Cooper University Health Care in Camden and
36 Christiana Care Health System in Wilmington, DE^{5,6}; and

Whereas, Section 5506 of the Affordable Care Act amended the Social Security Act (SSA) by adding subsection (vi) to section 1886(h)(4)(H) "Redistribution of Residency Slots After a Hospital Closes," which among other things sets priority for hospitals seeking allocation, but does not acknowledge or address prioritization or protections for trainees⁸⁻⁹; and

Whereas, Section 1886(h)(4)(H) of the SSA has been utilized 14 times since 2010 without clear standardized guidelines addressing the prioritization and protection of trainees¹⁰; and

Whereas, A 2015 Government Accountability Office report found that 47% of teaching hospitals were operating their GME programs above the Medicare full-time equivalent (FTE) cap on direct GME payments, utilizing supplemental funding from state Medicaid programs, private sources, other federal bodies, or paid for directly by the institution¹¹; and

Whereas, The ACGME, Association of American Medical Colleges (AAMC), National Resident Matching Program (NRMP), Educational Commission for Foreign Medical Graduates (ECFMG), and the Centers for Medicare and Medicaid Services (CMS) are each involved - be it directly or indirectly - in the process by which a displaced resident must seek an alternative training position; therefore be it

RESOLVED, That our American Medical Association study and provide recommendations on how the process of assisting orphaned residents and fellows could be improved in the case of training hospital or training program closure, including:

- 1) The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and
- 2) How the Centers for Medicare and Medicaid Services (CMS) and other additional or supplemental GME funding is re-distributed, including but not limited to:
 - a. The direct or indirect classification of residents and fellows as financial assets and the implications thereof;
 - b. The transfer of training positions between institutions and the subsequent impact on resident and fellow funding lines in the event of closure;
 - c. The transfer of full versus partial funding for new training positions; and
 - d. The transfer of funding for orphaned residents and fellows who switch specialties (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations which protect residents and fellows impacted by program or hospital closure which may include recommendations for:

- 1) Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions which minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
- 2) Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
- 3) Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and

1 4) Protections against the discrimination of orphaned residents and fellows
2 consistent with H-295.969 (Directive to Take Action); and be it further
3

4 RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical
5 Education, Association of American Medical Colleges, National Resident Matching Program,
6 Educational Commission for Foreign Medical Graduates, the Centers for Medicare and
7 Medicaid Services and other relevant stakeholders to identify a process by which orphaned
8 residents and fellows may be directly represented in proceedings surrounding the closure of a
9 training hospital or program (Directive to Take Action); and be it further
10

11 RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical
12 Education, Association of American Medical Colleges, National Resident Matching Program,
13 Educational Commission for Foreign Medical Graduates, the Centers for Medicare and
14 Medicaid Services, and other relevant stakeholders to:

- 15 1) Develop a stepwise algorithm for designated institutional officials and program
16 directors to assist residents and fellows with finding and obtaining alternative
17 training positions; and
18 2) Create a centralized, regulated process for orphaned residents and fellows to
19 obtain new training positions. (Directive to Take Action)

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

Received: 11/16/19

References:

1. Redford, G. What happens when a teaching hospital closes? AAMC News. 2019. Retrieved at: <https://news.aamc.org/medical-education/article/what-happens-when-a-teaching-hospital-closes/>
2. Ohio Valley Medical Center Closure. ACGME News. 2019. Retrieved at: <https://acgme.org/Newsroom/Newsroom-Details/ArticleID/9572/Ohio-Valley-Medical-Center-Closure>
3. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/9e/33/9e3304eb-4bb2-4950-b854-d3cd426c2deb/treatment_of_gme_funding_in_the_event_of_hospital_closure_final.pdf
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5. <https://www.inquirer.com/business/health/hahnnemann-bankruptcy-residency-sale-judge-approves-cms-20190905.html?outputType=amp>
6. https://why.org/articles/judge-rules-hahnnemann-can-sell-its-residency-programs-to-highest-bidder-closure-plan-delayed/?fbclid=IwAR0vJFg_adk1erkYglizl_aNoZ8KHu1tlpw_BnNMS3mxMkwkRQwyolvS5Nc
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11. U.S. Government Accountability Office. (2018, March). HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding. (Publication No. GAO-18-240). Retrieved from GAO Reports Main Page via GPO Access database: <https://www.gao.gov/assets/700/690581.pdf>

RELEVANT AMA POLICY:

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13;

Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Res., A-19; Modified: BOT Rep. 25, A-19

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

Citation: CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13; Appended: CME 05, A-16; Appended: Res. 319, A-16; Reaffirmation A-16

Securing Funding for Graduate Medical Education H-310.917

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

Citation: CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12; Reaffirmed: CME Rep. 5, A-13; Appended: CME Rep. 1, I-15

Reference Committee F

BOT Report(s)

06 Physician Health Policy Opportunity

08 Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership

CLRPD Report(s)

01 Academic Physicians Section Five-Year Review

HOD Comm on Compensation of the Officers

01* Report of the HOD Committee on Compensation of the Officers

Resolution(s)

602# Preserving Childcare at AMA Meetings

** Contained in Handbook Addendum*

Contained in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(I-19)

Introduced by: Young Physicians Section
Subject: Preserving Childcare at AMA Meetings
Referred to: Reference Committee F

1 Whereas, At the 2016 Annual meeting, the House of Delegates (HOD) adopted Policy
2 D-600.958, "Childcare at the AMA Meetings," which called for our AMA to initiate a three-year
3 pilot of onsite childcare at meetings of the House of Delegates; and
4

5 Whereas, An onsite childcare service has been provided by Accent on Children's
6 Arrangements, Inc. (Accent), which is fully licensed and uses caregivers with considerable
7 experience in working with children of a diverse range of ages. Users pay a fee to Accent for
8 the service on either a full- or half-day basis that varies with a child's age; and
9

10 Whereas, Accent provides childcare to 60-70 programs per year, including but not limited to the
11 American College of Obstetrics & Gynecology (national and district meetings), American
12 Academy of Pediatrics, American College of Surgeons, American College of Physicians,
13 American College of Emergency Physicians, American Urological Association, American
14 Thoracic Society, American Orthopaedic Foot and Ankle Society, California Medical Society,
15 Radiological Society of North America, and the American Heart Association;¹ and
16

17 Whereas, Several physician groups contracted with Accent (such as ACOG at national and
18 district meetings, AUA, and ACEP) charge *zero* user fees for the use of this service;¹ and
19

20 Whereas, Accent has been in business for 28 years, with no history of lawsuits or liability
21 concerns;¹ and
22

23 Whereas, Accent carries \$8 million in liability insurance and names our AMA as an additional
24 insured.¹ Further, as part of the current registration process to take part in Camp AMA, one
25 must sign a waiver of liability; and
26

27 Whereas, Our AMA routinely subsidizes the particular needs of certain member groups, such as
28 reduced-price memberships for medical students, residents, and early career physicians,
29 resulting in students paying AMA membership fees that are less than 5% of the fees for an
30 established physician that has completed training;² and
31

32 Whereas, Recent data has shown that the largest age cohort of AMA members is under 40
33 years of age; additionally, resident and fellow members make up nearly a quarter of AMA
34 members. Further, continuing to expand the diversity of our members and leaders to better
35 reflect the face of medicine has been identified in this context as a key goal for our organization.
36 This conversation has occurred in the absence of increasing membership costs, suggesting that
37 there is a greater value in engagement than the fiscal cost of membership;³ and

1 Whereas, The availability of reliable, well-vetted childcare provides the opportunity for more of
2 our AMA members with young families to fully engage in our AMA HOD, and it further signals to
3 potential members that our AMA members with young families are a valued part of our
4 organization; and

5
6 Whereas, For those with young families, the availability of childcare can mean the difference
7 between participation and non-participation in AMA-HOD activities; and

8
9 Whereas, 2010 AAMC data indicates that 11% of public medical school graduates and 29% of
10 private medical school graduates had debt over \$200,000; and these significant levels of
11 educational debt incurred by medical students, residents, and fellows may make user fees for
12 childcare a significant barrier to participation in our AMA House of Delegates, by AMA members
13 with young families;⁴ and

14
15 Whereas, Ethical Opinion E-9.5.5, "Gender Discrimination in Medicine," specifically states,
16 "Collectively, physicians should actively advocate for and develop *family-friendly* policies that
17 promote fairness in the workplace, including providing for... on-site childcare services for
18 dependent children"; therefore be it

19
20 RESOLVED, That our American Medical Association continue to arrange on-site supervised
21 childcare at AMA Annual and Interim meetings (New HOD Policy); and be it further

22
23 RESOLVED, That our AMA offer on-site supervised childcare at no cost to AMA members and
24 staff for Annual and Interim meetings. (New HOD Policy)

Fiscal Note: Indeterminate

Received: 11/16/19

RELEVANT AMA POLICY

Childcare at the AMA Meetings D-600.958

Our AMA will review best practices and initiate a three-year pilot of onsite childcare at AMA Annual and Interim meetings of the House of Delegates and Sections beginning at the 2017 Annual Meeting with a report back regarding utilization and its impact on participation at AMA meetings.

Citation: Res. 601, A-16

References

1. Personal communication, Tue 10/8/19 with Accent leadership
2. <https://www.ama-assn.org/ama-member-benefits/member-eligibility-dues/ama-membership-dues>
3. <https://www.ama-assn.org/system/files/2019-08/a19-clrpd-report-1.pdf>
4. Council on Medical Education Report 8-A-12 "Evaluation of Income-Contingent Medical Education Loans" at: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/a-12cmerpt8.pdf>.

Reference Committee J

CMS Report(s)

- 01 Established Patient Relationships and Telemedicine
- 02 Addressing Financial Incentives to Shop for Lower-Cost Health Care
- 03 Improving Risk Adjustment in Alternative Payment Models
- 04 Mechanisms to Address High and Escalating Pharmaceutical Prices

Resolution(s)

- 801 Reimbursement for Post-Exposure Protocol for Needlestick Injuries
- 802 Ensuring Fair Pricing of Drugs Developed with the United States Government
- 803 Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People
- 804 Protecting Seniors from Medicare Advantage Plans
- 805 Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard
- 806 Support for Housing Modification Policies
- 807 Addressing the Need for Low Vision Aid Devices
- 808 Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs
- 809 AMA Principles of Medicaid Reform
- 810 Hospital Medical Staff Policy
- 811 Require Payers to Share Prior Authorization Cost Burden
- 812* Autopsy Standards as Condition of Participation
- 813* Public Reporting of PBM Rebates
- 814* PBM Value-Based Framework for Formulary Design
- 815* Step Therapy
- 816# Definition of New Patient
- 817# Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans
- 818# Medical Center Auto Accept Policies
- 819# Hospital Website Voluntary Physician Inclusion
- 820# E-Cigarette and Vaping Associated Illness

** Contained in Handbook Addendum*

Contained in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-19)

Introduced by: Georgia

Subject: Definition of New Patient

Referred to: Reference Committee J

1 Whereas, The definition of a new patient to a medical practice is a patient who has never been
2 seen or a previous patient that has not been seen in three years; and
3

4 Whereas, A patient who has not been seen in over a year can have many major changes in
5 their medical status; and
6

7 Whereas, Since the patient has not been there in a while, there is data in many categories of
8 the evaluation that needs to be collected; and
9

10 Whereas, The necessary collection of this data takes extra time; therefore be it
11

12 RESOLVED, That our American Medical Association advocate for the definition of a “new
13 patient” to represent the multitude of factors and time needed to appropriately evaluate a
14 patient’s health condition and in accordance with relevant payer guidelines. (Directive to Take
15 Action)

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

Received: 10/24/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-19)

Introduced by: Georgia

Subject: Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans

Referred to: Reference Committee J

Whereas, There are [over 55 million people covered by Medicare, 1.5 million in Georgia; and](#)

Whereas, There are over 40 Medicare D and Advantage plans in metro Atlanta, making it unlikely that a person will pick the least expensive plan that covers their medicines. Some have a \$0 premium; and

Whereas, The plans have different copays, deductibles, formularies and premiums, thus the least expensive plan depends on what medicines a person is taking. The large number of options makes it unlikely that a person will choose the least expensive plan; and

Whereas, Research suggests average savings of \$368 annually for people on Medicare D if they picked the least expensive Medicare D plan that covered their medicines (greater for people with certain chronic diseases). This extrapolates to potential \$600 million savings for the 1.5 million people on Medicare in Georgia and \$21 billion for the 60 million people in the US on Medicare.

Whereas, 2012 census data suggests potential savings of over \$2 billion/year for the 5.4 million veterans and their spouses on Medicare who are not covered by the VA or Tricare; and

Whereas, [7 million people on Medicare have not picked a plan](#) to help cover their medicines; and

Whereas, [25 percent of people with cancer skip at least some of their treatments](#) due to the cost of medicines; and

Whereas, Research shows improved outcomes when financial barriers to care are lowered; and

Whereas, 73 percent of people who have trouble paying for food report choosing between paying for food and paying for medicine/medical care; and

Whereas, The [Medicare Plan Finder](#) (a free tool on medicare.gov) and State Health Insurance Assistance Programs (SHIP) are free federally funded resources to help your patients and relatives on Medicare find the least expensive plans which cover their medicines. The Georgia SHIP, GeorgiaCares, is administered by the Division of Aging Services (DAS). GeorgiaCares provides free one-on-one counseling in a limited number of locations throughout the state and over the phone (1-866-552-4464, Option 4); and

Whereas, GeorgiaCares would like to form partnerships with healthcare systems in Georgia;
and

Whereas, Open enrollment to pick a new Medicare D or Advantage Plan for next year is
October 15th - December 7th; therefore be it

RESOLVED, That our American Medical Association advocate for transparent patient
educational resources on their personal costs for their medications under Medicare Part D and
Medicare Advantage plans--both printed and online video--which health care systems could
provide to patients and which consumers could access directly (Directive to Take Action); and
be it further

RESOLVED, That our AMA advocate for increased resources for federal and state programs
like GeorgiaCares and educate physicians, hospitals, and patients about the availability of these
programs. (Directive to Take Action)

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

Received: 10/24/19

Additional Resources
EPIC Smartphrases

1. The nurse or care coordinator asks the following questions (EPIC smartphrase below, could be adapted for other EMRs):

Medicine costs

{IS/IS NOT: 22135} on Medicare

Has insurance to cover medicines: {YES NO: 22100}

Cost of Medicines is a problem {YES NO: 22100}

Would like to learn about help paying for medicines {YES NO: 22100}

2. If appropriate the following can be adapted and put in the After Visit Summary Smartphrase WMGMEDICARE

Want to learn about how people on Medicare (you, your relatives and friends) can lower the cost of their medicines by hundreds to thousands of dollars per year? A free online tool, the [Medicare Plan Finder](#) can help you find the least expensive Medicare Plan that covers your medicines. [GeorgiaCares](#), which provides one on one counseling about Medicare options.

Did you know there are 60 million people covered by Medicare, 1.5 million in Georgia?

Did you know that [7 million people on Medicare have not picked a plan](#) to help pay for their medicines?

Did you know that [25% of people with cancer skip at least some of their treatments](#) due to the cost of medicines?

Did you know that there are 40 Medicare medicine plans in Atlanta and that some have a \$0 premium?

A free video at www.medicaredrugsavings.org explains the different types of Medicare and how to lower your Medicare costs. Watch the video then use a free tool, [The Medicare Plan Finder](#), on www.Medicare.gov to find the least expensive plan to cover your medicines.

If you need more, help call [GeorgiaCares](#) (www.mygeorgiacares.org) at 1-866-552-4464 (option 4) for one-on-one help. You can also get information by calling 1-800-MEDICARE.

Open enrollment (the time for most people to pick a new plan for next year) is October 15 – December 7.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-19)

Introduced by: Organized Medical Staff Section

Subject: Medical Center Auto Accept Policies

Referred to: Reference Committee J

1 Whereas, Our AMA is pursuing strategic goals of improving health outcomes for patients, as
2 well as improving physician satisfaction; and
3

4 Whereas, As part of the above strategic goals, abolishing the dysfunction in healthcare that
5 compromises a patient's need to receive care at the right place, at the right time, and in the
6 most appropriate and cost-effective setting, and a physician's ability to provide same, should be
7 integral to this initiative; and
8

9 Whereas, Some medical centers have an "auto accept" (i.e. unconditional acceptance for care
10 of a patient) policy where the center will unconditionally accept a patient with an emergent
11 and/or serious condition for care, without consideration of the center's capacity to appropriately
12 care for that patient; and
13

14 Whereas, Such a blanket "auto accept" policy may in some instances compromise patient safety
15 and/or overtax staff capabilities; and
16

17 Whereas, In the opinion of many, such policies place profit ahead of patient and staff welfare;
18 therefore be it
19

20 RESOLVED, That our American Medical Association study the impact of "auto accept" policies
21 (i.e. unconditional acceptance for the care of a patient) on public health, as well as their
22 compliance with the Emergency Medical Treatment and Labor Act (EMTALA) in order to protect
23 the safety of our patients, with report back at the 2020 Annual Meeting (Directive to Take Action);
24 and be it further
25

26 RESOLVED, That our AMA advocate that if a medical center adopts an "auto accept" (i.e.
27 unconditional acceptance for the care of a patient) policy, it must have been ratified, as well as
28 overseen and/or crafted, by the independent medical staff. (New HOD Policy)

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

Received: 11/16/19

RELEVANT AMA POLICY

Limit Scope of EMTALA to Original Legislative Intent D-130.994

(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians;

(b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients;

(c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and

(d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement.

(2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose.

(3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting.

Citation: Sub. Res. 217, I-00; Reaffirmed: BOT Rep 6., A-10

Transfer of Emergency Patients H-130.982

Our AMA: (1) supports the following principles for the transfer of emergency patients: (a) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Guidelines for Transfer of Patients should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to their county medical societies as they develop such protocols and interhospital agreements with their local hospitals.

Citation: CMS Rep. H, A-86; Reaffirmed: BOT Rep. BB, A-90; Reaffirmed: CMS Rep. F, I-92; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10.

Refusal of Appropriate Patient Transfers H-130.965

Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred.

Citation: Sub. Res. 155, I-89; Reaffirmed: Sunset Report and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10.

Confusion Between Inappropriate Patient Transfer and Appropriate Patient Transfer H-130.968

Our AMA (1) believes that the use of the term "patient dumping" for inappropriate patient transfer is offensive and should be discontinued; and (2) supports efforts to educate physicians, the public, government officials, and the media and others regarding the difference between appropriate patient transfers, as defined in existing policy statements, and inappropriate patient transfers.

Citation: Sub. Res. 164, A-89; Reaffirmed: Sunset Report and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10.

Refusal of Appropriate Patient Transfers H-130.961

The AMA (1) continues to urge county medical societies to develop, with their local hospitals, protocols, and interhospital transfer agreements, and to urge state medical associations to assist their county societies as they develop such agreements; and

(2) encourages county medical societies and local hospitals to review and utilize the AMA Principles for the Transfer of Emergency Patients and the American College of Emergency Physicians' Principles of Appropriate Interhospital Patient Transfer as they develop local transfer arrangements.

Citation: BOT Rep. BB, A-90; Reaffirmation A-00; Modified: CMS Rep. 6, A-10.

Emergency Transfer Responsibilities H-130.957

Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to:

- (1) require that the Office of the Inspector General (IG) request and receive the review of the Peer Review Organization (PRO) prior to imposing sanctions;
- (2) make the PRO determination in alleged patient transfer violations binding upon the IG;
- (3) expand the scope of PRO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks;
- (4) restore the knowing standard of proof for physician violation;
- (5) recognize appropriate referral of patients from emergency departments to physician offices;
- (6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer;
- (7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient;
- (8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and
- (9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act.

Citation: Sub. Res. 78, A-91; Reaffirmation A-00; Reaffirmed: BOT Rep. 6; A-10.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-19)

Introduced by: Organized Medical Staff Section

Subject: Hospital Website Voluntary Physician Inclusion

Referred to: Reference Committee J

1 Whereas, Hospitals and other health care facilities traditionally use their websites to inform the
2 public of all their physicians on staff; and
3

4 Whereas, More and more hospitals and other health care facilities are employing more and
5 more physicians; and
6

7 Whereas, A growing trend of these hospitals and health care facilities is removing their
8 voluntary staff physicians from their websites and 'Find a Doctor' sites and listing only their
9 employed physicians; and
10

11 Whereas, Patients searching for a physician on these websites but not finding the voluntary
12 physicians may assume the physician is not on staff, retired, or not credentialed; therefore be it
13

14 RESOLVED, That our American Medical Association advocate for regulation and/or legislation
15 requiring that all credentialed physicians (employed and voluntary) of a hospital and/or other
16 healthcare facility be equally included on the websites and physician search engines, such as
17 Find a Doctor sites (Directive to Take Action); and be it further
18

19 RESOLVED, That our AMA study a requirement that all credentialed physicians (employed and
20 voluntary) of a hospital and/or other healthcare facility be equally included on the websites and
21 physician search engines, such as Find a Doctor sites with a report back at the 2020 Annual
22 Meeting. (Directive to Take Action)

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

Received: 11/16/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-19)

Introduced by: Resident and Fellow Section

Subject: E-Cigarette and Vaping Associated Illness

Referred to: Reference Committee J

Whereas, As of October 15, 2019, there were 1,479 lung injury cases associated with the use of e-cigarettes, or vaping, products reported from 49 states (all except Alaska), the District of Columbia and one U.S. territory, as well as 33 deaths confirmed in 24 states¹; and

Whereas, E-cigarettes are devices that produce an aerosol by heating a liquid containing various chemicals, including nicotine, flavorings, and other additives (e.g., propellants, solvents, and oils). E-liquids may also contain substances that are safe to eat but unsafe to inhale. Users inhale the aerosol, including any of these additives, into their lungs²; and

Whereas, Aerosols produced by e-cigarettes can contain harmful or potentially harmful substances, including heavy metals such as lead, volatile organic compounds, ultrafine particles, cancer-causing chemicals, or other agents such as chemicals used for cleaning the device²; and

Whereas, Preliminary reports from state health department investigations, a published case series of patients in Illinois and Wisconsin, and three other published case series, describe clinical features of pulmonary illness associated with e-cigarette product use^{2,3}; and

Whereas, Currently, there is no FDA-authorized or FDA-approved electronic nicotine delivery system⁴; and

Whereas, Currently, there is no coding classification for vaping-suspected lung injury and clinicians are encouraged to report possible cases to their local or state health department for further investigation; and

Whereas, The Centers for Disease Control and Prevention (CDC) is still investigating the specific cause of these illnesses and state public health officials are to also promptly notify CDC about possible cases and refer to CDC for the most recent versions of the surveillance case definitions, reporting guidelines, and case investigation forms^{1,2}; and

Whereas, The widely used International Classification of Diseases 10th Edition Clinical Modification (ICD-10-CM) does not contain any specific diagnosis codes for use or toxicity related to e-cigarettes or vaporizers, making it difficult to perform large scale epidemiological studies using clinical or insurance claims data⁵; and

Whereas, Evidence demonstrates that youth are especially attracted to flavored e-cigarette products⁶; and

Whereas, Businesses and states have taken action against e-cigarettes, such as New York, Michigan, Rhode Island and Utah states banning the sale of flavored e-cigarettes as well as Walmart and Sam's Club ending the sales of e-cigarettes⁷; and

Whereas, Juul Labs recently announced that it suspended sales of mango, crème, fruit and cucumber flavored e-cigarette pods in the United States; Mint, menthol and tobacco will continue to be sold^{8,9}; therefore be it

RESOLVED, That our American Medical Association advocate for diagnostic coding systems including ICD codes to have a mechanism to release emergency codes for emergent diseases (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for creation and release of ICD codes to include appropriate diagnosis codes for both the use of and toxicity related to e-cigarettes and vaping, including pulmonary toxicity. (Directive to Take Action)

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

Received: 11/16/19

References:

1. Outbreak of Lung Disease Associated with E-Cigarette Use, or Vaping. Centers for Disease Control and Prevention. Accessed Oct 18 2019. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html
2. Severe Pulmonary Disease Associated with Electronic-Cigarette–Product Use — Interim Guidance. Centers for Disease Control and Prevention. September 6 2019. https://www.cdc.gov/mmwr/volumes/68/wr/mm6836e2.htm?s_cid=mm6836e2_e&deliveryName=USCDC_921-DM8485
3. Layden, J., Ghinai, I., Pray, I., Kimball, A., Laver, M., Tenforde, M., Navon, L., Hoots, B., Salvatore, P., Elderbrook, M., Haupt, T., Kanne, J., Patel, M., Saathoff-Huber, L., King, B., Schier, J., Mikosz, C., Meiman, J. (2019). Pulmonary Illness Related to E-Cigarette Use in Illinois and Wisconsin — Preliminary Report. New England Journal of Medicine <https://dx.doi.org/10.1056/nejmoa1911614>
4. FDA Regulation of Electronic Nicotine Delivery Systems and Investigation of Vaping Illnesses. Sep 25 2019. <https://www.fda.gov/news-events/congressional-testimony/fda-regulation-electronic-nicotine-delivery-systems-and-investigation-vaping-illnesses-09252019>
5. International Classification of Diseases, Tenth Revision. World Health Organization. <https://icd.who.int/browse10/2016/en>
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7. States & Localities that have Restricted the Sale of Flavored Tobacco Products. Campaign for Tobacco-Free Kids <https://www.tobaccofreekids.org/assets/factsheets/0398.pdf>
8. Juul Suspends Online Sales of Flavored E-Cigarettes. <https://www.nytimes.com/2019/10/17/health/vaping-juul-e-cigarettes.html>
9. E-cigarette giant Juul suspends sales of several flavored vape pods. <https://www.washingtonpost.com/health/2019/10/17/e-cigarette-giant-juul-suspends-online-sales-mango-three-other-flavors/>

RELEVANT AMA POLICY:

Electronic Cigarettes, Vaping, and Health H-495.972

1. 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.
2. 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.
3. 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. 412, 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

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.

Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18

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.

Citation: CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12; Reaffirmation A-13; Modified: Res. 402, A-13; Modified: Speakers Rep., A-14; Appended: Res. 420, A-14; Reaffirmation A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed in lieu of: Res. 412, A-19; Modified: CSAPH Rep. 03, 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, I-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 412, A-15; Reaffirmed in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Reaffirmation A-16; Appended: Res. 429, A-18; Modified: CSAPH Rep. 05, A-18

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

Reference Committee K

CSAPH Report(s)

- 01 Mandatory Reporting of Diseases and Conditions
- 02 Real-World Data and Real-World Evidence in Medical Product Decision Making
- 03 Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals

Resolution(s)

- 901 Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water
- 902 Amending H-490.913, Smoke-Free Environments and Workplaces, and H-409.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to Include E-Cigarettes
- 903 Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications
- 904 Amendment to AMA Policy H-150.949, "Healthy Food Options in Hospitals"
- 905 Sunscreen Dispensers in Public Spaces as a Public Health Measure
- 906 Ensuring the Best In-School Care for Children with Sickle Cell Disease
- 907 Increasing Access to Gang-Related Laser Tattoo Removal in Prison and Community Settings
- 908 Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians
- 909 Decreasing the Use of Oximetry Monitors for the Prevention of Sudden Infant Death Syndrome
- 910 Ban on Electronic Nicotine Delivery System (ENDS) Products
- 911 Basic Courses in Nutrition
- 912 Improving Emergency Response Planning for Infectious Disease Outbreaks
- 913 Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use
- 914 Nicotine Replacement Therapy for Minors
- 915 Preventing Death and Disability Due to Particulate Matter Produced by Automobiles
- 916 Sale of Tobacco in Retail Pharmacies
- 917 Supporting Research Into the Therapeutic Potential of Psychedelics
- 918 Banning Flavors, Including Menthol and Mint, in Combustible and Electronic Cigarettes and Other Nicotine Products
- 919 Raising Awareness of the Health Impact of Cannabis
- 920 Maintaining Public Focus on Leading Causes of Nicotine-Related Death
- 921 Vaping in New York State and Nationally
- 922 Understanding the Effects of PFAS on Human Health
- 923 Support Availability of Public Transit System
- 924 Update Scheduled Medication Classification
- 925* Suspending Sales of Vaping Products/Electronic Cigarettes Until FDA Review
- 927* Climate Change
- 928* CBD Oil and Supplement Use in Treatment
- 929* Regulating Marketing and Distribution of Tobacco Products and Vaping-Related Products
- 930# Origin of Prescription Medication Production Transparency
- 931# Vaping Ban for Under 21 and Additional Regulations
- 932# Source and Quality of Medications Critical to National Health and Security
- 933# Supporting Research Into the Therapeutic Potential of Psychedelics
- 934# Gun Violence and Mental Illness Stigma in the Media
- 935# AMA Response to a National Vaping Epidemic

* Contained in Handbook Addendum

Contained in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 930
(I-19)

Introduced by: Georgia

Subject: Origin of Prescription Medication Production Transparency

Referred to: Reference Committee K

1 Whereas, Several generic medications in 2019, especially Angiotensin-receptive Blockers
2 (ARBs), were found in many pills to contain a cancer-causing agent, nitrosamine; and
3

4 Whereas, In the United States, the trade name drugs as well as many generics are
5 manufactured in highly regulated facilities and are in American pharmacies; and
6

7 Whereas, Many generics that are obtained by pharmacists for patients come from generic drug
8 purchasing and distribution agents or online and are often manufactured in foreign countries
9 such as China, India, or third world countries where there is little or no regulation, and this
10 appears to have occurred with the ARBs; and
11

12 Whereas, Studies show that exposure over time to these cancer-causing contaminants could
13 cause irreparable harm; and
14

15 Whereas, It is imperative that patients when purchasing their medications have clear knowledge
16 and transparency of where the pills were manufactured to decide if they want to buy them;
17 therefore be it
18

19 RESOLVED, That our American Medical Association advocate to Congress to support national
20 legislation to make it a requirement that the identity of the manufacturer(s) and the country
21 (countries) of origin of the components of prescription medications be included on the label of
22 the container dispensed to a patient, including generic medications. (Directive to Take Action)

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

Received: 10/24/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 931
(I-19)

Introduced by: Georgia

Subject: Vaping Ban for Under 21 and Additional Regulations

Referred to: Reference Committee K

1 Whereas, It is a known fact that nearly 95 percent of adult smokers began smoking before age
2 21; and
3

4 Whereas, Approximately 4.9 million middle and high school students were current tobacco
5 users in 2018; and
6

7 Whereas, The percent of high school seniors who had used an e-cigarette in the past 30 days
8 increased from 1.5 percent in 2010 to 26.7 percent in 2018; and
9

10 Whereas, Use among 8th grade students has more than doubled; and
11

12 Whereas, Eighth grade students who use e-cigarettes are 10 times more likely than their peers
13 who do not use e-cigarettes to eventually smoke tobacco cigarettes; and
14

15 Whereas, It is suggested that adolescents and teens who use e-cigarettes are likely to become
16 regular tobacco smokers as they get older; and
17

18 Whereas, E-juice contains nicotine which is addictive and changes the teens developing brain
19 by causing perturbations of cholinergic systems; and
20

21 Whereas, Some studies suggest that nicotine exposure may induce epigenetic changes that
22 sensitize the brain to other drugs and prime it for future substance abuse; and
23

24 Whereas, Increasing the legal age to purchase tobacco and e-cigarettes to 21 will reduce
25 tobacco use among youth and young adults; and
26

27 Whereas, Nearly all tobacco use begins during the teenage and adolescent years; and
28

29 Whereas, Increasing the legal age to 21 will help keep tobacco out of high schools, where
30 younger students often get e-cigarette products from older students; and
31

32 Whereas, A 2015 report by the National Academy of Medicine concluded that increasing the
33 tobacco sale age to 21 would improve public health and have both immediate and long-term
34 benefits; and
35

36 Whereas, In Georgia, tobacco kills 11,700 people and costs over \$3 billion in health care
37 expenses each year; and

1 Whereas, 204,000 kids now under 18 and alive in Georgia will ultimately die prematurely from
2 smoking; and

3
4 Whereas, Increasing the tobacco age to 21 will reduce tobacco's terrible toll on the health of all
5 Georgia residents; and

6
7 Whereas, The FDA in 2009 banned all flavors in cigarettes other than menthol, to protect the
8 American public, particularly children from being attracted to cigarettes; and

9
10 Whereas, Currently there are 15,500 flavors of e-juice and pods including sweet candy flavors
11 that attract kids; and

12
13 Whereas, The American College of Physicians (ACP) recommends that characterizing flavors
14 should be banned from all tobacco products, including electronic nicotine delivery systems
15 (ENDS); and

16
17 Whereas, The ACP supports legislative or regulatory efforts to restrict promotion, advertising,
18 and marketing for ENDS products in the same manner as for combustible cigarettes, including a
19 prohibition on television advertising. Youth tobacco prevention efforts, such as antismoking
20 media campaigns and school-based interventions, should include information about the
21 potential risks of ENDS use; and

22
23 Whereas, 18 states have raised the age to 21 to legally purchase tobacco and e-cigarettes;
24 therefore be it

25
26 RESOLVED, That our American Medical Association reaffirm policy on tobacco sales and
27 flavoring and renew efforts to advocate to make these policies universal in all the states in the
28 Union. (Directive to Take Action)

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

Received: 10/24/19

RELEVANT AMA POLICY

Tobacco Advertising and Media H-495.984

Our AMA:

- (1) in keeping with its long-standing objective of protecting the health of the public, strongly supports a statutory ban on all advertising and promotion of tobacco products;
- (2) as an interim step toward a complete ban on tobacco advertising, supports the restriction of tobacco advertising to a "generic" style, which allows only black-and-white advertisements in a standard typeface without cartoons, logos, illustrations, photographs, graphics or other colors;
- (3) (a) recognizes and condemns the targeting of advertisements for cigarettes and other tobacco products toward children, minorities, and women as representing a serious health hazard; (b) calls for the curtailment of such marketing tactics; and (c) advocates comprehensive legislation to prevent tobacco companies or other companies promoting look-alike products designed to appeal to children from targeting the youth of America with their strategic marketing programs;
- (4) supports the concept of free advertising space for anti-tobacco public service advertisements and the use of counter-advertising approved by the health community on government-owned property where tobacco ads are posted;
- (5) (a) supports petitioning appropriate government agencies to exercise their regulatory authority to prohibit advertising that falsely promotes the alleged benefits and pleasures of smoking as well worth the risks to health and life; and (b) supports restrictions on the format and content of tobacco

- advertising substantially comparable to those that apply by law to prescription drug advertising;
- (6) publicly commends those publications that have refused to accept cigarette advertisements and supports publishing annually, via JAMA and other appropriate publications, a list of those magazines that have voluntarily chosen to decline tobacco ads, and circulation of a list of those publications to every AMA member;
- (7) urges physicians to mark the covers of magazines in the waiting area that contain tobacco advertising with a disclaimer saying that the physician does not support the use of any tobacco products and encourages physicians to substitute magazines without tobacco ads for those with tobacco ads in their office reception areas;
- (8) urges state, county, and specialty societies to discontinue selling or providing mailing lists of their members to magazine subscription companies that offer magazines containing tobacco advertising;
- (9) encourages state and county medical societies to recognize and express appreciation to any broadcasting company in their area that voluntarily declines to accept tobacco advertising of any kind;
- (10) urges the 100 most widely circulating newspapers and the 100 most widely circulating magazines in the country that have not already done so to refuse to accept tobacco product advertisements, and continues to support efforts by physicians and the public, including the use of written correspondence, to persuade those media that accept tobacco product advertising to refuse such advertising;
- (11) (a) supports efforts to ensure that sports promoters stop accepting tobacco companies as sponsors; (b) opposes the practice of using athletes to endorse tobacco products and encourages voluntary cessation of this practice; and (c) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products;
- (12) will communicate to the organizations that represent professional and amateur sports figures that the use of all tobacco products while performing or coaching in a public athletic event is unacceptable. Tobacco use by role models sabotages the work of physicians, educators, and public health experts who have striven to control the epidemic of tobacco-related disease;
- (13) (a) encourages the entertainment industry, including movies, videos, and professional sporting events, to stop portraying the use of tobacco products as glamorous and sophisticated and to continue to de-emphasize the role of smoking on television and in the movies; (b) will aggressively lobby appropriate entertainment, sports, and fashion industry executives, the media and related trade associations to cease the use of tobacco products, trademarks and logos in their activities, productions, advertisements, and media accessible to minors; and (c) advocates comprehensive legislation to prevent tobacco companies from targeting the youth of America with their strategic marketing programs; and
- (14) encourages the motion picture industry to apply an "R" rating to all new films depicting cigarette smoking and other tobacco use.

Citation: (CSA Rep. 3, A-04; Appended: Res. 427, A-04; Reaffirmation A-05; Reaffirmation A-14)

Opposition to Addition of Flavors to Tobacco Products H-495.971

Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of flavored tobacco products; (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of flavored tobacco products; and (3) encourages the FDA to prohibit the use of flavoring agents in tobacco products, which includes electronic nicotine delivery systems.

Citation: CSAPH Rep. 01, A-18; Modified: Res. 916, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 932
(I-19)

Introduced by: Pennsylvania

Subject: Source and Quality of Medications Critical to National Health and Security

Referred to: Reference Committee K

Whereas, On September 13, 2018 Bloomberg reported carcinogens have been found in generic as well as brand name forms of ranitidine Zantac¹; and

Whereas, There are no entities within the United States that presently produce Penicillin, Doxycycline or Ciprofloxacin or other medications critical to public health and security against biowarfare agents such as Anthrax²; and

Whereas, It is the duty of the Federal Government through its U.S. Food and Drug Administration (FDA) to oversee compounding, production, quality and supply of pharmaceuticals and their chemical substrates, regardless of their geographic origin³; and

Whereas, There are several medications in shortage which endangers public health and security⁴; and

Whereas, Pharmaceuticals and their chemical substrates may be manufactured in geographies not under adequate supervision by the FDA⁴; and

Whereas, Over 80% of USA pharmaceuticals and their chemical substrates originate in China²; and

Whereas, There is a history of toxic and carcinogenic pharmaceuticals and their chemical substrates supplied by China^{5,6,7}; and

Whereas, Pharmaceuticals manufactured in a foreign country may source substrates supplied by yet another foreign country neither of which may have a chain of quality assurance⁸; therefore be it

¹ <https://www.msn.com/en-us/finance/companies/carcinogen-in-zantac-and-generics-triggers-fda-eu-probes/ar-AAHfEO5>

² China Rx by Rosemary Gibson, Janardan Prasad Singh Publisher: Prometheus; 1st Edition (April 17, 2018) Language: English ISBN-10: 1633883817 ISBN-13: 978-1633883819

³ <https://www.fda.gov/drugs/human-drug-compounding/compounding-oversight>

⁴ <https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm>

⁵ FDA requirement to oversee china laboratories <https://www.fiercepharma.com/regulatory/fda-adding-inspectors-china-but-for-now-it-has-only-2-b>

⁶ FDA warning letters to Chinese companies <https://www.cnn.com/2018/08/06/chinas-growing-drug-scandal-is-having-a-ripple-effect-around-the-world.html>

⁷ Carcinogens Have Infiltrated the Generic Drug Supply in the U.S.: An FDA quality-control nightmare reveals how impurities and up in America's blood pressure pills. By Anna Edney, Susan Berfield, and Evelyn Yu Set 12, 2019 Bloomberg Business Week

⁸ Bottle of Lies: The Inside Story of the Generic Drug Boom by Katherine Eban Publisher: Ecco; 1 edition (May 14, 2019) Language: English ISBN-10: 0062338781 ISBN-13: 978-0062338785

1 RESOLVED, That our American Medical Association support studies that identify the extent to
2 which the United States is dependent on foreign supplied pharmaceuticals and chemical
3 substrates (New HOD Policy); and be it further
4

5 RESOLVED, That our AMA support legislative and regulatory initiatives that help to ensure
6 proper domestic capacity, production and quality of pharmaceutical and chemical substrates as
7 a matter of public well-being and national security (New HOD Policy); and be it further
8

9 RESOLVED, That our AMA encourage the development and enforcement of standards that
10 make the sources of pharmaceuticals and their chemical substrates used in the United States of
11 America transparent to prescribers and the general public. (New HOD Policy)

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

Received: 10/29/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 933
(I-19)

Introduced by: Maryland

Subject: Supporting Research Into the Therapeutic Potential of Psychedelics

Referred to: Reference Committee K

Whereas, Psychedelics are a class of drugs that produce mind-altering states, which includes psilocybin, lysergic acid diethylamide (LSD), and mescaline¹; and

Whereas, Between 1950-1965, research into the therapeutic effects of psychedelics produced over 1,000 scientific papers and six international conferences, with promising results for alcoholism, depression, and a variety of other mental disorders¹; and

Whereas, In the late 1960s, this promising research was halted when the FDA scheduled psychedelics as Schedule 1 drugs, due to both the dangers associated with their unregulated use and their association with the “counterculture” movement¹; and

Whereas, There has been a recent resurgence of interest in the therapeutic application of psychedelics for patients with depression, anxiety, addiction, and a host of other psychiatric conditions¹; and

Whereas, Despite their reported dangers in unregulated situations, such as accidental traumatic injuries, psychedelics have proven to be notably safe when administered in a regulated environment, with no long-term physical effects, tissue toxicity, or interference with liver function; scant drug–drug interaction²; and limited addictive properties²⁻⁴; and

Whereas, Studies have reported subjects who experience acute negative emotions after psychedelic use (paranoia, anxiety, etc), these emotions are short lasting and rarer in incidence than positive emotions⁵; and

Whereas, There is little evidence of adverse effects of psychedelics in habitual users, who use more often and use at a larger dose than experimental studies, and as of now, no evidence of persistent perceptual disturbances, known as ‘hallucinogen persisting perceptual disorder’ (HPPD)⁶; and

Whereas, A large population study in the USA found no link between the use of psychedelics and any mental health problems⁶; and

Whereas, The therapeutic index (TI) of both LSD and psilocybin is at least 1000, which is notably higher than that of morphine (TI = 70) and alcohol (TI = 10)^{7,8}; and

Whereas, A number of prominent researchers and physicians have spoken out in support of expanding research on psychedelics⁹; and

1 Whereas, LSD led to a 22% reduction in STAI (State-Trait Anxiety Inventory) state anxiety at 2
2 months in patients with a life-threatening illness, and reductions was sustained through 12
3 months¹⁰; and
4

5 Whereas, Psilocybin has been associated with a 55% reduction in Beck Depression Inventory
6 (BDI) scores at 3 months in patients with Major Depressive Disorder, remission of depression by
7 BDI in 60-80% of patients with life-threatening cancer at 6.5 months, a 44% reduction in Yale-
8 Brown Obsessive Compulsive score at 24 hours in patients with Obsessive-Compulsive
9 disorder, an 80% abstinence rate at 6 months for smoking cessation and a 68% reduction in
10 heavy drinking at 13-24 weeks for treatment of substance use disorders¹¹⁻¹⁵; and
11

12 Whereas, In a randomized double-blind study of 51 participants with anxiety and depression
13 associated with life-threatening cancer, a one-time psilocybin administration with guided therapy
14 resulted in a 50% reduction in symptoms at 6 months post treatment in 78% of patients for
15 anxiety, and 83% of patients for depression¹⁶; and
16

17 Whereas, Phase 2 trials testing MDMA with 107 participants with PTSD, 56% no longer
18 qualified for PTSD after treatment with MDMA-assisted psychotherapy, and 12-months later,
19 68% no longer had PTSD¹⁷; and
20

21 Whereas, The current classification of psychedelic compounds as Schedule 1 means that their
22 use is prohibited except for very limited scientific research studies requiring an extensive and
23 costly approval process^{4,6}; and
24

25 Whereas, Drugs are considered Schedule 1 if they meet three criteria: first, the drug or other
26 substance has a high potential for abuse; second, the drug or other substance has no currently
27 accepted medical use in the United States; and third, there is a lack of accepted safety for use
28 of the drug or other substance under medical supervision⁴; and
29

30 Whereas, Current AMA policies regarding the regulation of “psychoactive” and “psychotropic”
31 drugs only emphasize the health risks associated with such drugs and do not address the
32 previously stated contemporary research showing their therapeutic potential, their limited
33 addictive risk, and their limited risk when delivered in a controlled, regulated environment¹⁻¹⁷
34 (H-95.940); and
35

36 Whereas, Our AMA already has policy encouraging rescheduling of and research into other
37 pharmaceuticals such as cannabis and cannabinoids (H-120.926 and H-95.952); and
38

39 Whereas, The AMA MSS has adopted this resolution into their policies; therefore be it
40

41 RESOLVED, That our American Medical Association work to establish a waiver process for
42 psychedelics as Schedule 1 substances with the goal of facilitating clinical research. (Directive
43 to Take Action)

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

Received: 11/06/19

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RELEVANT AMA POLICY

Expedited Prescription Cannabidiol Drug Rescheduling H-120.926

Our AMA will: (1) encourage state controlled substance authorities, boards of pharmacy, and legislative bodies to take the necessary steps including regulation and legislation to reschedule U.S. Food and Drug Administration (FDA)-approved cannabidiol products, or make any other necessary regulatory or legislative change, as expeditiously as possible so that they will be available to patients immediately after approval by the FDA and rescheduling by the U.S. Drug Enforcement Administration; and (2) advocate that an FDA-approved cannabidiol medication should be governed only by the federal and state regulatory provisions that apply to other prescription-only products, such as dispensing through pharmacies, rather than by these various state laws applicable to unapproved cannabis products. Citation: Res. 502, A-18;

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.

Citation: CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of: Res. 434, A-19;

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)

Emerging Drugs of Abuse are a Public Health Threat D-95.970

Our AMA will participate as a stakeholder in a Centers for Disease Control and Prevention/U.S. Drug Enforcement Administration (CDC/DEA) taskforce for the development of a national forum for discussion of new psychoactive substances (NPS)-related issues.

Citation: CSAPH Rep. 02, A-17; Reaffirmed in lieu of: Res. 512, A-18;

Addressing Emerging Trends in Illicit Drug Use H-95.940

Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat; (2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, other educational materials, and public awareness campaigns; (3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders; (4) encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat; (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and (6) supports efforts by federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.

Citation: Sub. Res. 901, I-14; Modified: CSAPH Rep. 02, A-17; Reaffirmed: Res. 503, A-18; Reaffirmed in lieu of: Res. 512, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 934
(I-19)

Introduced by: Maryland

Subject: Gun Violence and Mental Illness Stigma in the Media

Referred to: Reference Committee K

Whereas, In the wake of recent mass shootings, there have been statements in the media about mental health and gun violence, with examples including “(1) that mental illness causes gun violence, (2) that psychiatric diagnosis can predict gun crime, (3) that shootings represent the deranged acts of mentally ill loners, and (4) that gun control “won’t prevent” another Newtown (Connecticut school mass shooting)”;¹ and

Whereas, Between 2005-2014, an analysis of a sample of national news stories about mental illness showed that 56% of stories mentioned violence related to mental illness and of those stories, 75% detailed a specific violent event by a person with mental illness--most often a gun violence event (32%) or a mass shooting event (22%);² and

Whereas, News media portrayals of mass shooting events that describe the shooter as having serious mental illness increase people’s negative attitudes toward those with serious mental illness, heightening desired social distance from and perceived dangerousness of those with serious mental illness;³ and

Whereas, A 2013 Gallup poll showed that 80% of adult Americans placed blame (“a great deal” and “a fair amount” of blame) on the mental health system for mass shootings, while around 40% blamed easy access to guns, showing the responsibility that we have to clarify the statistics surrounding mass shootings for the knowledge of the general public;⁴ and

Whereas, A 2017 CBS poll found that 68% of Americans believe that better mental health screening could help prevent gun violence a lot;⁵ and

Whereas, Experts on gun violence rank other measures to reduce mass shootings, such as banning assault weapons and universal background checks, as more effective than expanding mental health treatment;⁶ and

Whereas, Mental health care spending, mental health professionals per capita, and the rate of severe mental health disorders is not higher in the US compared to other developed countries, which have lower rates of mass shootings;⁷ and

Whereas, “Most people who are violent are not mentally ill, and most people who are mentally ill are not violent”;⁸ and

Whereas, The National Center for Health Statistics indicates that fewer than 5% of the 120 000 gun-related killings in the United States between 2001 and 2010 were perpetrated by people diagnosed with mental illness;⁹ and

1 Whereas, Mass shootings by people with serious mental illness represent less than 1% of all
2 yearly gun-related homicides; in contrast, deaths by suicide using firearms account for nearly
3 two-thirds of yearly gun-related deaths, or 20,000 deaths per year;¹⁰ and
4

5 Whereas, There is little evidence to support that those diagnosed with mental illness are more
6 likely than anyone else to commit a crime with a gun;¹ and
7

8 Whereas, Substance use, substance use with comorbid serious mental illness, a parental
9 history of abuse and/or neglect, and binge drinking more strongly correlate with violence/gun
10 violence than mental illness alone;¹¹ and
11

12 Whereas, Although some mass shooters are found to have a history of psychiatric illness, no
13 reliable research has suggested that a majority of perpetrators are primarily influenced by
14 serious mental illness;¹⁰ and
15

16 Whereas, “Higher rates of firearm ownership are associated with higher rates of overall suicide
17 and firearm suicide”;¹² and
18

19 Whereas, Stigma towards mental health can be structurally incorporated into legislation, such
20 as gun laws that restrict firearm privileges “targeting people with mental illness per se rather
21 than people who are incompetent as a result of having a mental illness”;¹³ and
22

23 Whereas, Stigma toward those with mental illness, including a perception that they are
24 dangerous or aggressive, may deter patients from seeking health care;¹⁴ and
25

26 Whereas, Health care professionals may harbor stigma against mental illness for the same
27 reasons;¹⁵ and
28

29 Whereas, The American Psychiatric Association, in response to mass shootings in Texas and
30 Ohio, released a statement on August 4th, 2019 stating, “Routinely blaming mass shootings on
31 mental illness is unfounded and stigmatizing. Research has shown that only a very small
32 percentage of violent acts are committed by people who are diagnosed with, or in treatment for,
33 mental illness.” and instead pointed to the access and lethality of firearms as greater risk factors
34 for mass shootings¹⁶; and
35

36 Whereas, The Maryland State Medical Society (MedChi) submitted a letter in 2018 asking “the
37 AMA work with all appropriate specialty societies to develop and disseminate fact sheets for
38 discussing mental illness and violence in the media in an effort to enhance the accuracy of
39 media reports concerning mental health and gun violence and to reduce the stigma associated
40 with mental health;” and
41

42 Whereas, The AMA response states Resolution 212 (I-18) “Development and Implementation of
43 Guidelines for Responsible Media Coverage of Mass Shootings” covers this topic; and
44

45 Whereas, Resolution 212 (I-18) reads as follows: “Our AMA encourages the Centers for
46 Disease Control and Prevention, in collaboration with other public and private organizations, to
47 develop recommendations or best practices for media coverage of mass shootings”; and
48

49 Whereas, Resolution 212 does not specifically include responsible media coverage regarding
50 mental illness and gun violence and therefore the AMA has no accountability for prioritizing this
51 topic in its future actions; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-145.971, "Development
2 and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings,"
3 by addition to read as follows:

4
5 Our AMA encourages the Centers for Disease Control and Prevention, in
6 collaboration with other public and private organizations, to develop
7 recommendations or best practices for media coverage of mass shootings, including
8 for accurate and sensitive discussion of the purported relationship between mental
9 illness and gun violence. (Modify Current HOD Policy)

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

Received: 11/06/19

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- ² Emma E. McGinty, Alene Kennedy-Hendricks, Seema Choksy, and Colleen L. Barry. Trends In News Media Coverage Of Mental Illness In The United States: 1995–2014. *Health Affairs* 2016 35:6, 1121-1129 <https://www.healthaffairs.org.ezp.welch.jhmi.edu/doi/10.1377/hlthaff.2016.0011>
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- ¹² Matthew Miller, Catherine Barber, Richard A. White, Deborah Azrael; Firearms and Suicide in the United States: Is Risk Independent of Underlying Suicidal Behavior?, *American Journal of Epidemiology*, Volume 178, Issue 6, 15 September 2013, Pages 946–955, <https://doi.org/10.1093/aje/kwt197>
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- ¹⁴ Aphroditi Zartaloudi, Michael Madianos. Stigma related to help-seeking from a mental health professional. *Health Science Journal* 2010 4:2, 77-83
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RELEVANT AMA POLICY

Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings H-145.971

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage of mass shootings.

Citation: Res. 212, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 935
(I-19)

Introduced by: Organized Medical Staff Section

Subject: AMA Response to a National Vaping Epidemic

Referred to: Reference Committee K

Whereas, There have been several resolutions brought forth addressing serious concerns about e-cigarettes in recent years at the various levels within the AMA; and

Whereas, Many of these have come from the OMSS, with calls for the AMA to assume a strong public position taking leadership regarding this public health issue; and

Whereas, “Better public health” is a goal of the AMA and at the same time there has been escalating injury and addiction from vaping; and

Whereas, Healthcare and education responses to date have been inadequate to stem the tide of this epidemic, and

Whereas, AMA policy H-495.986 has already recognized that vaping is in fact an epidemic; therefore be it

RESOLVED, That our American Medical Association adopt an immediate AMA declaration that the vaping epidemic has escalated, leading to life-threatening illnesses and if unchecked will become an epidemic of epic proportions, labeling it now as a National Public Health Emergency Crisis (Directive to Take Action); and be it further

RESOLVED, That our AMA, having declared vaping a Public Health Emergency Crisis, advocate for an immediate legislative ban on vaping at the national level, with a minimal duration of one year and which emulates shorter bans already in place in several states (Directive to Take Action); and be it further

RESOLVED, That during any ban on vaping, our AMA advocate for emergency government research funding, under the direction of the Centers for Disease Control and Prevention, at a level sufficient to study and combat both the nicotine addiction and the direct pulmonary toxicity from the use of electronic nicotine delivery systems (Directive to Take Action); and be it further

RESOLVED, That our AMA direct the Public Education Programs of the AMA to disseminate its own teaching materials (or those of sister organizations) to warn of the dangers of vaping. Such materials would be tailored for specific age group blocks, beginning with the late primary school age group (Directive to Take Action); and be it further

RESOLVED, That our AMA adopt an immediate declaration and advocate for legislative action that requires the vaping industry to follow the same restrictions as the tobacco industry in direct-to-consumer advertising/marketing of their products. (Directive to Take Action)

Fiscal Note: Estimated cost of \$50,000 to implement this resolution.

Received: 11/16/19

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, I-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 412, A-15; Reaffirmed in lieu of Res. 419, A-15; Reaffirmed Res. 421, A-15; Reaffirmation A-16; Appended: Res. 429, A-18; Modified: CSAPH Rep. 05, A-18

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.

Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 8917, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18

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.

Citation: CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12; Reaffirmation A-13; Modified: Res. 402, A-13; Modified: Speakers Rep., A-14; Appended: Res. 420, A-14; Reaffirmation A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed in lieu of: Res. 412, A-19; Modified: CSAPH Rep. 03, A-19

Not for consideration

Resolutions not for consideration

008 Improving the Health and Safety of Consensual Sex Workers

012* Study of Forced Organ Harvesting by China

601 Amending AMA Policy G-630.140, "Lodging, Meeting Venues, and Social Functions"

926* School Resource Officer Qualifications and Training

** Contained in Handbook Addendum*

Contained in Sunday Tote