REPORTS OF THE BOARD OF TRUSTEES

The following reports, 1–46, were presented by Gerald E. Harmon, MD, Chair.

1. ANNUAL REPORT

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FILED

The Consolidated Financial Statements for the years ended December 31, 2017 and 2016 and the Independent Auditor's report have been included in a separate booklet, titled "2017 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

2. NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.984

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Rhinologic Society, American Society for Reconstructive Microsurgery, American Society of Neuroimaging, North American Neuromodulation Society, and the North American Neuro-Ophthalmology Society for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by each organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. All five organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the 2017 Interim Meeting indicated that: American Rhinologic Society, American Society for Reconstructive Microsurgery, American Society of Neuroimaging, North American Neuromodulation Society, and the North American Neuro-Ophthalmology Society meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Rhinologic Society, American Society for Reconstructive Microsurgery, American Society of Neuroimaging, North American Neuromodulation Society, and the North American Neuro-Ophthalmology Society be granted representation in the AMA House of Delegates and that the remainder of the report be filed.

APPENDIX

Exhibit A, Guidelines for Representation in and Admission to the House of Delegates: National Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.
2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (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:
   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been 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 5 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.

Responsibilities of National Medical Specialty Organizations

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Rhinologic Society	172 of 265 (65%)
American Society for Reconstructive Microsurgery	168 of 663 (25%)
American Society of Neuroimaging	105 of 280 (38%)
North American Neuromodulation Society	260 of 942 (28%)
North American Neuro-Ophthalmology Society	100 of 454 (22%)

3. 2017 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This informational financial report details all grants or donations received by the American Medical Association during 2017.

American Medical Association
Grants & Donations received by AMA
For the Year Ended December 31, 2017
Amounts in thousands

Funding Institution	Project	Amount Received
Agency for Healthcare Research & Quality (subcontracted through Northwestern University)	Midwest Small Practice Care Transformation Research Alliance	$ 299
Centers for Disease Control and Prevention (subcontracted through National Association of Chronic Disease Directors)	Diabetes Technical Assistance and Support	243
Centers for Disease Control and Prevention (subcontracted through YMCA)	Diabetes Prevention Program	9
Centers for Medicare Medicaid Services	Transforming Clinical Practices Initiative — Support and Alignment Networks	453
Centers for Medicare & Medicaid Services (subcontracted through Mathematica Policy Research, Inc.)	Quality Measures for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees	53
Substance Abuse and Mental Health Services Administration (subcontracted through American Academy of Addiction Psychiatry)	Providers Clinical Support System for Opioid Therapies	91
Government Funding		**1,148**
American Association of Colleges of Osteopathic Medicine	Accelerating Change in Medical Education Initiative	13
American College of Physicians	International Congress On Peer Review and Scientific Publication	10
American Medical Association Foundation via contributions from Eli Lilly and Company	Accelerating Change in Medical Education Conference	9
American Medical Association Foundation via contributions from Genentech, Inc.	Accelerating Change in Medical Education Conference	45
American Medical Association Foundation via contributions from Pfizer, Inc.	Accelerating Change in Medical Education Conference	23
American Medical Association Foundation via contributions from The Physicians Foundation	Joy in Medicine Research Summit	57
American Osteopathic Association	Accelerating Change in Medical Education Initiative	13
Public Library of Science	International Congress On Peer Review and Scientific Publication	10
Stanford University	International Congress On Peer Review and Scientific Publication	30
The Marcus Foundation, Inc.	Evaluation of a Virtual Interactive Platform in Enhancing Diagnostic Reasoning and Improving Diagnostic Accuracy	788
Nonprofit Contributors		**998**
BioMed Central	International Congress On Peer Review and Scientific Publication	10
Copyright Clearance Center, Inc.	International Congress On Peer Review and Scientific Publication	5
Precision Computer Works, Inc.	International Congress On Peer Review and Scientific Publication	5
Silverchair Science + Communications, Inc.	International Congress On Peer Review and Scientific Publication	10
Wolters Kluwer Health	International Congress On Peer Review and Scientific Publication	30
Contributions less than $5,000	International Congress On Peer Review and Scientific Publication	2
Contributions less than $5,000	International Medical Graduates Section Reception	8
Other Contributors		**70**
Total Grants and Donations		**$ 2,216**

4. AMA 2019 DUES

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
**   REMAINDER OF REPORT FILED**
*   See Policy G-635.130*

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2019 Membership Year

The Board of Trustees recommends no change to the dues levels for 2019, that the following be adopted and that the remainder of this report be filed:

Regular Members	$ 420
Physicians in Their Second Year of Practice	$ 315
Physicians in Military Service	$ 280
Physicians in Their First Year of Practice	$ 210
Semi-Retired Physicians	$ 210
Fully Retired Physicians	$ 84
Physicians in Residency Training	$ 45
Medical Students	$ 20

5. UPDATE ON CORPORATE RELATIONSHIPS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2017. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association's (AMA) corporate relationships, HOD Policy G-630.040, "Principles on Corporate Relationships." These "Guidelines for American Medical Association Corporate Relationships" were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2017 RESULTS

In 2017, forty-four new activities were considered and approved through the corporate review process. Of the forty-four projects recommended for approval, thirteen were conferences or events, nine were education, content or grants, nineteen were collaborations or affiliations, and three were member service provider programs (Appendix B).

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

APPENDIX A - Corporate Review Process Overview

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions Group (HSG), Advocacy, Federation Relations, Office of the General Counsel, Medical Education, Publishing, Ethics, Enterprise Communications and Marketing (ECM), Physician Engagement (PE), and Health and Science.

The CRT evaluates each project with the following criteria:

- Type, purpose and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Fit or conflict with AMA Corporate Guidelines;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or CPT licensing.)
- Member service provider programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions only if there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.
In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees. The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

APPENDIX B - Summary of Corporate Review Recommendations for 2017

Project No.	Project Description	Corporations	Approval Date
CONFERENCES/EVENTS			
27797	Sandy Hook Promise Gala – Continue AMA sponsorship, name and logo use for the June 2017 event.	Sandy Hook Promise The Sorenson Family Standard and Poor (S&P) Global, Inc. Verizon Wireless Mehlman Castagnetti Rosen & Thomas Akin Gump Straus Hauer & Feld, LLP	5/10/2017

American Health Care Association (AHCA)
Discovery Communications, Inc.
Bank of America
Lockheed Martin Corporation
Anthem, Inc.
Association for Accessible Medicines (AAM)
  American Telephone & Telegraph, Inc.
  (AT&T)
General Dynamics Corporation
CVS Health
PepsiCo, Inc.
Lumina Foundation
Genentech, Inc. (A Member of the Roche
  Group)
Comcast Corporation
Blue Cross / Blue Shield Association
Pharmaceutical Research and Manufacturers of
  America (PhRMA)
Amalgamated Band
Pacific Gas & Electric Company (PG&E)
National Association of Broadcasters (NAB)
Aetna Inc.
Liberty Partners Group, LLC
Managed Funds Association (MFA)

27981	Alliance for Health Policy Dinner – Repeating AMA sponsorship for 2017 event to support advocacy.	Alliance for Health Policy (formerly Alliance for Health Reform)	8/4/2017
28216	Bellin Health Training Days – AMA sponsorship, name and logo use for Bellin Health conference for their nine step practice transformation framework.	Bellin Health Systems Institute for Healthcare Improvement (IHI)	6/22/2017
28451	National Quality Forum (NQF) Annual Conference Sponsorship – Continue AMA sponsorship, name and logo use for NQF Annual Conference "Fulfilling The Quality Mandate."	National Quality Forum (NQF) Merck & Co., Inc. Janssen Global Services, LLC Kaiser Permanente Novartis, AG Deloitte Compassus America's Essential Hospitals Utilization Review Accreditation Commission (URAC) Henry Ford Health System Battelle Memorial Institute Heron Therapeutics, Inc. American Health Care Association (AHCA) / National Center for Assisted Living (NCAL) Federation of American Hospitals American Hospital Association (AHA) Health Care Service Corporation (HCSC) UnitedHealth Group Encompass Health Corporation Relias WellDoc, Inc. Zero Suicide Institute National Committee for Quality Assurance (NCQA) Unite Us Fair Health, Inc	11/21/2017

29117	American Conference on Physician Health (ACPH) – AMA name and logo association with Stanford University and the Mayo Clinic for conference on physician well-being.	Stanford University Mayo Clinic The Physician Foundation Coalition for Physician Well-Being	1/20/2017
29213	2017 ChangeMed National Conference – External sponsorship for AMA ChangeMed conference on innovation and medical education.	ChangeMed Healthcare Eli Lilly Elsevier Pfizer Genentech, Inc. (A Member of the Roche Group)	2/15/2017
29472	2017 Sling Health Demo Day – AMA sponsoring national Sling Health Demo Day.	Sling Health Bank of America St. Louis Bioscience (BioSTL) St. Louis Cardinals Community Development Ventures, Inc. Entrepreneur's Organization iSelect Pharmaceutical Research and Manufacturers of America (PhRMA) St. Louis Local Businesses (Randall's, Sameem's, Schlafly, Urban Chestnut) St. Louis Metropolitan Medical Society	4/27/2017
29797	Reach Media Collaboration – AMA Improving Health Outcomes (IHO) sponsorship of the Tom Joyner Family Reunion and Take a Loved One to the Doctor Day events.	Read Media Limited Community Health of South Florida, Inc.	6/22/2017
29835	2017 Health 2.0 Annual Fall Conference – AMA name, logo and sponsorship for physician burnout workshop.	Health 2.0 TracendInsights Cigna Health Insurance United Healthcare Services, Inc. Allscripts Developer Program Datica Health, Inc. Nordic Innovation House California Health Care Foundation Zynx Health Incorporated dotHealth, LLC Privis Health Utila, LLC Berg Analytics, LLC Distil Networks, Inc. Healow, Health and Online Wellness Outcomes Rocket Humetrix Nason Group Adaptive Sound Technologies, Inc. Proper Pillow M. Ventures B.V. Thinair Veta Health Consonance Companies, Inc. Venebio Group, LLC Stitch, Inc.	8/4/2017
29938	AMA Sponsorship of 2017 Connected Health Conference – AMA sponsoring the 2017 Connected Health Conference.	Healthcare Information and Management Systems Society (HIMSS) American Association of Retired Persons, Inc. (ARRP) Intel Phillips Verizon	8/1/2017

30050	AMA / AHIMA Clinical Documentation Improvement (CDI) Outpatient Workshop – AMA and AHIMA co-sponsoring a one day workshop on CDI.	American Health Information Management Association	8/10/2017
30210	2017 Forbes Healthcare Summit – AMA name, logo and sponsorship to highlight opioid epidemic and showcase new AMA initiatives.	Forbes America's Biopharmaceutical Companies Bayer CVS Health Northwell Health City of Hope Comprehensive Cancer Center	9/7/2017
30362	2018 National Rx Drug Abuse & Heroine Summit – AMA name and logo use as event supporter.	The National Rx Drug Abuse & Heroine Summit	10/11/2017

EDUCATION, CONTENT OR GRANTS

29414	Teaching EMR – AMA name and logo use on Regenstrief Teaching EMR website and materials as acknowledgement of AMA's Accelerating Change in Medical Education grant support.	The Regenstrief Institute	4/6/2017
29570	Evaluation of Interactive Virtual Technology in Teaching (i-Human Platform) – A controlled AMA research study to evaluate the effectiveness of interactive technology, assess diagnostic reason and improve accuracy utilizing the i-Human platform and funding from the Marcus Foundation.	The Marcus Foundation i-Human Patients, Inc.	5/4/2017
29647	AMA and *The Wall Street Journal* Custom Content Digital Platform – AMA developed content for use in an AMA / WSJ co-branded platform.	*The Wall Street Journal*	5/24/2017
29749	Sling Health – Chapter Expansion Grants – An AMA grant, name and logo association with Sling Health for student chapter expansion and community on AMA Physician Network.	Sling Health	6/6/2017
29866	Support for Human Diagnosis Project's Uninsured Digital Physician Consult Program – The AMA support for MacArthur grant process.	Human Diagnosis Project MacArthur Foundation American College of Physicians	7/7/2017
30190	Content Collaboration with Ingenious Med – AMA name and logo association with AMA content on Ingenious Med website.	Ingenious Med	9/12/2017
30492	AMA and The Atlantic: Custom Content Digital Platform – AMA developed content for use in an AMA / The Atlantic co-branded platform.	*The Atlantic*	10/16/2017
30540	Collaboration with Gaples Institute – Integrative Cardiology nutrition curriculum for AMA Education Center.	Gaples Institute for Integrative Cardiology	10/24/2017

| 30804 | AMA-AAPL Physician Leadership Education Curriculum – Physician Satisfaction and Practice Sustainability (PS2) and the AMA Education Center in partnership with the American Academy of Physician Leadership (AAPL) to develop co-branded physician leadership curriculum. | American Academy of Physician Leadership (AAPL) | 11/21/2017 |

COLLABORATIONS/AFFILIATIONS

25556	Addition of American Stroke Association to the Target: BP Initiative – Addition of American Stroke Association to previously approved AMA Improving Health Outcomes (IHO), and American Heart Association, Target: BP program.	American Stroke Association American Heart Association	7/21/2017
27962	Collaborative Study on Opioid Prescribing Activity with Premier Inc. – Premier / AMA collaboration, name and logo association on research designed to reduce opioid-related harms.	Premier Inc.	10/12/2017
28930	AMA Collaboration with Samsung SHealth – AMA to grant Samsung a non-exclusive, royalty free license to display AMA IHO diabetes resources in the Samsung SHealth phone application for U.S. users.	Samsung	9/15/2017
28964	AMA Physician Opportunities Portal (POP) – Organization name and logo association with AMA POP interactive tool to identify extra clinical opportunities	National Court Appointed Special Advocates (CASA) Association	4/17/2017
29341	AMA / KPMG Co-branded MACRA Survey – A survey to gather physician feedback on the start of the MACRA Quality Payment Program.	Klynveld Peat Marwick Goerdeler (KPMG)	3/7/2017
29414	AMA / Accenture Co-branded Cybersecurity Research – A physician survey on cybersecurity and HIPAA compliance.	Accenture	3/23/2017
29520	Health Affairs Precision Health Sponsorship – Co-sponsorship of a "precision medicine" theme issue of the *Health Affairs* journal.	The Robert Wood Johnson Foundation Precision Health Economics Illumina Pharmaceutical Research and Manufacturers of America (PhRMA) Genentech, Inc. (A Member of the Roche Group) Patients Center Outcomes Research Institute (PCORI)	4/19/2017
29723	AMA Collaboration with Pew and Medstar on EHR Best Practices – Conduct research and publish report to improve usability and safety of EHRs.	PEW Charitable Trusts MedStar Health Research Institute	6/27/2017
29760	Center for Healthcare Innovation Sponsorship –The AMA name and logo to be used on the website and program collateral for The 7th annual Diversity, Inclusion, & Life Sciences Symposium.	Center for Healthcare Innovation National Biotechnology and Pharmaceutical Association National Hispanic Life Sciences Society Women in Healthcare and Life Sciences	6/9/2017

		Gilead Sciences, Inc. Drinker, Biddle & Reath, LLP. Merrill Lynch Northwestern Medicine Robert H. Lurie Comprehensive Cancer Center Aurora Health Care Bridge Clinical Research and Chiltern	
29929	Partners HealthCare Digital Health Provider Adoption Study – AMA collaboration and logo use for Partners HealthCare research study to improve clinical adoption of digital health solutions.	Partners HealthCare System, Inc. (PHS)	7/21/2017
29985	Human Diagnosis Project Alliance – AMA name and logo association with Alliance to address gaps in specialty care for the underserved.	Human Diagnosis Project The American Board of Internal Medicine (ABIM) The American Board of Specialties (ABMS) The Association of American Medical Colleges (AAMC) The Association of Clinicians for the Underserved (ACU) National Association of Community Health Centers (NACHC) The Dartmouth Institute for Health Policy and Clinical Practice MIT Computer Science & Artificial Intelligence Lab (CSAIL)	8/1/2017
30105	2017 TEDMED Collaboration – Recognition as TEDMED global partner for the AMA.	TEDMED	8/23/2017
30208	Lucro Collaboration –To improve digital health solutions through integration of AMA guidelines and solutions into Lucro's healthcare marketplace platform.	Lucro Global, LLC	9/15/2017
30260	Physician Innovation Network (PIN) Supporters – Recognizing organizations that contribute resources or cross promote the AMA Physician Innovation Network.	Physician Innovation Network (PIN) MATTER Sling Health Lucro Global, LLC Healthbox, LLC AngelMD, Inc. Texas Medical Center Accelerator (TMCx) Plug and Play Tech Center Techstars Corporation Society of Physicians Entrepreneurs (SOPE) Red Crow Crowd, Inc. Health 2047 SMART 1776 Node Health Healthcare Innovation and Technology Lab, Inc. (HITLAb) Cambia Health Solutions, Inc. BluePrint Health StartUP Health Catalyst HTI Health 2.0 Insight Product Development, LLC Health: Further American Association of Retired Persons (AARP) MedStar Health	9/15/2017

30233	AMA / HITRUST Collaboration – Workshop on cybersecurity frameworks for small physician practices.	Health Information Trust Alliance (HITRUST) Binder Dijker Otte (BDO) Global	9/22/2017
30327	Integrated Health Model Initiative (IHMI) Collaborators – AMA name and logo association with external companies as supporters of the IHMI digital platform.	International Business Machines (IBM) Prometheus Research Apervita Cerner CareCloud American Heart Association (AHA) Patient-Centered Outcomes Research Institute (PCORI) Private Company Price Index (PCPI) NEST Coordinating Center (NESTcc) American Diabetes Association (ADA) Patients Like Me American Medical Informatics Association (AMIA) Snomed CareMore The Geisinger Health System (GHS) Bioreference Laboratories Clinical Architecture M*Modal Optum360 Intermountain Healthcare Partners Healthcare University of California San Francisco (UCSF) American Society of Anesthesiology (ASA) American College of Cardiology (ACC) American Academy of Family Physicians (AAFP) American Academy of Pediatrics (AAP) American Academy of Allergy, Asthma, & Immunology (AAAAI) American College of Physicians (ACP) American College of Surgeons (ACS) Epic Qualcomm Life Medstro Omada Healthcare Trust of America (HTA) Minnesota Mining and Manufacturing (3M) Partners Healthcare Kaiser Permanente HumanDx Apple Samsung Google Logical Observation Identifiers Names and Codes (LOINC) United Healthcare UC Health	9/22/2017
30451	Rand Payment Model Study – AMA name and logo on co-branded study book. Study entitled, "Effects of health care payment models on physician practice in the United States."	RAND	10/12/2017
30493	HIMSS Annual Conference Collaboration – Continuing AMA participation and logo use for HIMSS annual conference.	Healthcare Information and Management Systems Society (HIMSS)	10/16/2017

30576	Collaborative Study on Antibiotic Stewardship with The Pew Charitable Trusts – Pew / AMA name and logo use on research to assess prescribing practices and the need for antibiotic stewardship in outpatient healthcare settings.	The Pew Charitable Trusts	10/20/2017

MEMBER SERVICE PROVIDER PROGRAMS

28966	AMA Insurance Agency (AMAI) Ultimate Health Digital Health Benefits – AMA's partnership with Armadacare and Kelsey National for digital, medical and dental benefits.	Armadacare / ArmadaGlobal Kelsey National Corporation	1/6/2017
29057	AMA Insurance Agency (AMAI) Digital Platform – AMA Insurance relationship with NextGen Insurance Group for digital insurance customer acquisition platform.	Next Generation Insurance Group LLC	1/12/2017
	AMA Insurance Agency Carrier Change – Carrier change to New York Life Insurance Company to replace AIG for AMA – sponsored Life Insurance, AMA-sponsored Disability Insurance, AMA-sponsored Office Overhead Expense Insurance, and AMA-sponsored Accidental Death Insurance plans.	New York Life Insurance Company	9/28/2017

6. REDEFINING AMA'S POSITION ON ACA AND HEALTHCARE REFORM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. BOT Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

EFFORTS TO REPEAL THE ACA

Beginning prior to the introduction on March 7, 2017 of the component parts of what would become the American Health Care Act through the Senate's failure to adopt the so-called "skinny bill" in the early morning hours of July 28, 2017, the AMA consistently engaged with policy makers in support of AMA policies related to the Affordable Care Act. While acknowledging that improvements were needed in the ACA, the AMA opposed repeal on the basis of several policy points adopted by the House of Delegates. Specifically:

- Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans;
- Maintain key insurance market reforms, such as pre-existing conditions, guaranteed issue and parental coverage for young adults;
- Stabilize and strengthen the individual insurance market;
- Ensure that low/moderate income patients are able to secure affordable and meaningful coverage;
- Ensure that Medicaid, The Children's Health Insurance Program (CHIP) and other safety net programs are adequately funded;

- Reduce regulatory burdens that detract from patient care and increase costs;
- Provide greater cost transparency throughout the health care system;
- Incorporate common sense medical liability reforms; and
- Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends.

A number of factors played into the inability of Congress to advance repeal of the ACA, including the decision to act under the limitations imposed by the budget reconciliation process and efforts to go beyond ACA reform to include significantly restructuring the financing of the Medicaid program without hearings or stakeholder input. Ideological differences among Republican members of Congress and discomfort with projections of significant increases in the number of Americans without health insurance as a result of Congressional action further compromised the pathway to repeal.

Following the failure to repeal ACA as a whole or in part, Congress was expected to turn to efforts to stabilize the current system in the short term through continuing Cost-Sharing Reduction (CSR) payments to health plans and reinsurance. However, despite bipartisan efforts to reach agreement, no plan to strengthen the ACA marketplaces had been brought to the floor for a vote. On October 12, 2017, President Trump announced that we would end CSR payments, which had continued to be made during pending litigation on their legality. On the same day, the President signed an Executive Order directing relevant agencies to explore options for more people to buy health insurance that is exempt from many of the ACA's requirements.

As a result of the Executive Order, the Administration has released two proposed rules. The first, released January 4, 2018, would allow more flexibility to groups and small businesses to join together in an association health plan (AHP). While the AMA supports efforts to maximize health plan choices for individuals and small businesses, the policy of the House of Delegates also calls on the AMA to work with federal legislators to ensure that AHP programs safeguard state and federal patient protection laws. In comments to the Department of Labor (DOL) on the proposal, the AMA urged DOL to withdraw the proposed rule and work with state insurance commissioners and health care stakeholders to seek a solution that would expand affordable insurance coverage options through AHPs without undermining state authority to regulate AHPs to protect patients and physicians against such things as fraud and insurer solvency. AMA expressed concern that "DOL's proposal does not maintain key consumer protections and does not meet the AMA's key principles on health system reform ... and would result in substandard health insurance coverage."

The AMA also warned that without proper oversight to account for insolvency and fraud, AHPs have the potential to increase already high insurance premiums and overall health care costs, while threatening patients' health and financial security and the financial stability of physician practices and made recommendations to address those concerns.

On February 20, 2018, the Administration released a second proposed rule in keeping with the Executive Order, this time to make it easier for individuals to buy health plans that do not comply with ACA coverage requirements. The proposal would extend the time that consumers may be covered by short-term, limited duration health plans that are not required to comply with coverage requirements from three months to 364 days. These plans may not provide coverage for pre-existing conditions and benefits such as maternity care and mental health care are often excluded. Critics have charged that the proposal would fracture the individual market, though administration officials have disagreed with that assessment. At this writing, the AMA is reviewing the proposal.

Throughout the autumn of 2017, Congress also turned its attention to tax reform. While many in Congress had considered the possibility of using tax reform to repeal portions of the ACA, such as the requirement to obtain coverage, to take advantage of the protections from filibuster afforded it by the Reconciliation process, others expressed serious reservations. Many thought that including efforts to undermine ACA would erode support for the tax legislation. On November 8, 2017, the Congressional Budget Office (CBO) released an estimate that repeal of the individual mandate would result in 13 million fewer individuals having health coverage and premiums increasing an average of 10 percent. However, CBO also predicted that repeal would produce $338 billion in budgetary savings over 10 years, savings which could be used to offset some of the deficits produced by the growing tax cut proposal. On November 16, 2017, the Tax Cuts and Jobs Act bill passed the House by a vote of 227-205. The Senate followed on December 2, 2017 on a vote of 51-49. On December 19, the reconciled version of the Tax Cuts

and Jobs Act passed both chambers and was signed into law by President Trump December 22, 2017. The new law eliminates the penalty for failure to obtain coverage repealing the individual mandate beginning in 2019.

REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-PERFORMANCE

Our AMA continues to work with Congress and the Administration on the implementation of and improvements to the Quality Payment Program (QPP) established by the Medicare Access and CHIP Reauthorization Act (MACRA). Considerable progress was made in this regard through multiple provisions of the Bipartisan Budget Act of 2018.

On February 9, 2018, the President signed the Bipartisan Budget Act of 2018. The budget bill accomplished a number of critical Congressional priorities, including enacting continuing appropriations through March 22 and setting spending caps for fiscal years 2018 and 2019, suspending the debt ceiling for approximately one year, providing badly needed disaster relief (including increased Medicaid spending for Puerto Rico and the U.S. Virgin Islands as called for by the AMA House of Delegates), extending CHIP reauthorization for an additional four years (through 2027) and addressing the so-called Medicare extenders, including repealing Medicare outpatient therapy caps.

As a result of the work of our AMA and numerous state and national specialty medical associations, a number of improvements to the QPP program were included in the final bill. These included additional flexibility on the establishment of performance thresholds and the application of cost measures, both of which will allow the Centers for Medicare & Medicaid Services to continue to work with the physician community on implementation issues rather than having to proceed immediately to more stringent requirements. Provisions of MACRA that applied the Merit-based Incentive Payment System (MIPS) payment adjustments to Part B drugs were also repealed and the authority of the Physician-focused Payment Model Technical Advisory Committee (PTAC) to provide technical assistance to physicians developing alternative payment models was clarified and broadened. Additionally, the requirement that the Advancing Care Information requirements for physicians under MIPS become more stringent each year was repealed.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Bipartisan Budget Act of 2018 also repealed the IPAB which had been put into place by the ACA. Prior to its repeal, no appointments had ever been made to IPAB and the requirement for recommendations for Medicare cuts by the board was never triggered.

SUPPORT FOR MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS, AND THE MEDICARE PATIENT EMPOWERMENT ACT

While the AMA continues to support efforts to expand access to health savings accounts and expand the use of flexible spending accounts, including support of the "Restoring Access to Medication Act," no new developments have occurred since the last meeting of the HOD.

The Medicare Patient Empowerment Act has not been reintroduced in the 115th Congress. The AMA will continue to seek opportunities, however, to increase private contacting opportunities under the Medicare program without penalty to the patient or physician.

STEPS TO LOWER HEALTH CARE COSTS

Policymakers continue to explore legislative and regulatory options to reduce the cost of care, particularly as it relates to the costs of pharmaceuticals. While dozens of bills have been introduced and multiple Congressional hearings have been held, no action on these proposals has been scheduled to date. Our AMA continues to engage physicians and the public through www.TruthinRX.org, including collecting patient stories.

On February 28, 2018, a bipartisan group of U.S. Senators, including Sen. Bill Cassidy, MD, (R-LA) wrote to the AMA and other health care stakeholders regarding their efforts "to increase health care price and information transparency to empower patients, improve the quality of health care, and lower health care costs." The letter requests stakeholder views on currently available information, what is not available, different methods to achieve price transparency, and other "common-sense" policies to empower patients and lower health care costs. Our AMA

will respond to the inquiry and looks forward to engaging with these Senators and others on ways to lower health care costs.

One way to lower costs that is not in dispute is to lower the tremendous amount of time, effort, and resources that go into complying with overly burdensome, duplicative, and unnecessary administrative and regulatory requirements that do not benefit patient care. Physicians and other providers are spending more and more time on paperwork and less time directly on patient care, driving up costs for everyone. Since last summer, the House Committee on Ways and Means has been collecting information from health care providers as part of its Medicare Red Tape Relief Project. In announcing the efforts, Ways and Means Chairman Kevin Brady (R-TX) stated "we will be doing outreach to health care providers, doctors, nurses, hospitals, clinicians on what red tape and regulation out of Washington is interfering with the doctor-patient relationship, driving up the cost of health care, or simply getting in the way of the highest quality health care possible. And so Chairman Tiberi is going to be the one leading that effort. It will include soliciting ideas on what the Administration and executive branch can do, as well, and ultimately leading – we hope – to some action legislatively, as well." While Subcommittee Chairman Tiberi has left Congress, we are pleased that the new Subcommittee Chairman, Peter Roskam (R-IL), has taken up this mantle, and we will continue to work with him and the committee to identify regulatory changes that can reduce the burden of providing care to Medicare beneficiaries as well as lower health care costs for all.

REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

Guidance released by the Department of Health and Human Services in 2014 included a positive interpretation of health plan requirements under section 2706(a) of the ACA, specifically clarifying that the section does not require "that a group health plan or health insurance issuer contract with any provider willing to abide by the terms and conditions for participation." Nevertheless, the AMA will continue to seek legislative opportunities to repeal this provision.

CONCLUSION

While much of the federal activity since the 2017 Interim Meeting of the House of Delegates has centered on tax cuts and budgetary issues, health care is never far from the center of the debate. As we have over the last several months, our AMA will continue to seek opportunities to advance the policies that are the subject of this report as well as others adopted by the HOD.

7. AMA PERFORMANCE, ACTIVITIES AND STATUS IN 2017

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy G-605.050, "Annual Reporting Responsibilities of the AMA Board of Trustees," calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extends across all physicians, as well as policymakers, thought leaders and medical schools, the AMA is uniquely positioned to deliver results-focused initiatives that enable physicians to answer a national imperative to measurably improve the health of the nation.

Creating Thriving Physician Practices: Tools For The Field

PS2 Research: The AMA and KPMG surveyed 1,000 practicing physicians in the U.S. who had some awareness of the Medicare and Chip Reauthorization Act of 2015 (MACRA) and are involved in practice decisions related to the Quality Payment Program (QPP). This research aimed to better understand physician preparation and positioning for the QPP in 2017, which was the first reporting year under the program. Key findings of this research have helped the

AMA develop educational and training resources for physicians, and have helped carve a path forward for practices participating or planning to participate in alternative payment models and the Merit-based Incentive Payment System (MIPS) through the QPP. The findings of this research were published in June 2017.

In a special report co-authored by senior AMA staff and published in *The New England Journal of Medicine*, relevant policy trends were identified and key recommendations made to grow the body of evidence on telehealth care delivery. This will have the potential to accelerate telehealth adoption, allowing physicians to enhance their delivery of clinical care.

Digital Health: The AMA formally launched the AMA Physician Innovation Network. Since launch in October, more than 2,070 users (companies and physicians) have joined the site. More than 1,100 of the users are physicians. There have been 1,000+ connection requests sent through the site, approximately 100 opportunities created thus far and numerous collaborators that have signed on to cross promote our efforts (e.g., MATTER, TMCx, Healthbox, and the Society of Physician Entrepreneurs).

More than 1.7 million clinical documents were shared in October 2017 among health care organizations through the Carequality Interoperability Framework. The rate of exchange has been rapidly accelerating each month as 2 million documents were exchanged in total for the first 12 months. With existing users continuing to onboard clients, and more than a half dozen users expected to go live in the first quarter of 2018, there will be continued growth.

Xcertia, an mHealth app collaborative effort pioneered by the AMA, the American Heart Association (AHA), the DHX Group, and the Healthcare Information and Management Systems Society (HIMSS), builds on each organization's ongoing efforts to foster safe, effective, and reputable health technologies. Initial content for Xcertia has been completed covering four areas: operability, security, privacy, and clinical evidence, and was released for public comment. The feedback will inform where to focus 2018 work group efforts.

Physician Payment and Quality: The AMA is working diligently so that practicing physicians are integral partners in the movement toward a thriving value-based health care system. AMA has created resources and tools for physicians and practice leaders that provide strategic guidance and education, implementation and decision support, and practice financial forecasting, among others.

By providing doctors with tools such as the AMA MIPS Action Plan (https://apps.ama-assn.org/pme/#/actionplan), we assisted physician decision-making and participation in Medicare's QPP, and in their making the larger move to value-based reimbursement.

Practice Transformation: The Professional Satisfaction and Sustainability unit's (PS2) efforts in measuring physician burnout expanded with the addition of residency programs. We have worked closely with our partners in adapting the Mini-Z to measure burnout amongst residents and fellows. PS2 partnered with AMA Membership in designing and piloting this tool. We confirmed burnout assessments with 11 residency programs across the country. This is an excellent opportunity to further understand the resident and fellow experience, as well as opportunities to identify solutions to enhance the practice of medicine for the next generation of clinicians.

The AMA developed seven new modules in 2017 for STEPS Forward™:
• Creating the organizational foundation for Joy in Medicine
• Adopting OpenNotes: Partnering with patients
• Adult vaccinations: Team-based immunization
• Building a patient experience program
• EHR in-basket restructuring for improved efficiency
• Embedding pharmacists into the practice
• Managing type 2 diabetes: A team-based approach

Guiding Professional Development: A Commitment To Physician Growth

In collaboration with IHO, the ACE consortium created and piloted educational programing within the chronic disease prevention and management curriculum at four medical schools. The consortium, also in conjunction with IHO, developed a unique history and physical tool emphasizing biopsychosocial factors. This tool is being piloted at two medical schools.

Osteopathic residencies are now being accredited by ACGME, and staffers have been rapidly adding these newly accredited residencies to FREIDA Online, the AMA Residency & Fellowship Database. Searches for osteopathic residencies increased 95 percent in 2017 compared to 2016. There are now 455 programs on FREIDA that have osteopathic recognition or are formerly American Osteopathic Association accredited programs.

The Regenstrief EHR Clinical Learning Platform, an EHR specifically created for educational settings by Indiana University School of Medicine and the Regenstrief Institute with financial support from the ACE consortium, launched and is now used by five schools.

Innovations emerging from the ACE consortium continued to spread. Health systems science is increasingly recognized as the third pillar of medical education and taught alongside the other two pillars, basic and clinical science. The *Health Systems Science* textbook, published by Elsevier in December 2016, sold thousands of copies around the world and was adopted by 12 schools across the United States.

Chronic Care: Improving Health Outcomes

The AMA and American Heart Association launched a national "Health Care Provider High Blood Pressure Education" campaign that has garnered more than 500K acts of engagement via our various platforms. These platforms include Target: BP, a web platform that offers physician practices and health systems access to the new Target: BP Improvement Program (based on the 2017 Hypertension Guideline), which includes self-measured blood pressure as a key component to drive improved health outcomes.

In the fourth quarter of 2017 IHO co-led the successful launch of a new "National High Blood Pressure Awareness Consumer" campaign in collaboration with the AHA and the Ad Council that has already yielded more than 400K visitors to the campaign website (loweryourhbp.org) and garnered $747M in donated media placements across the country.

To date IHO is actively engaged with 11 state medical societies that will serve as models to help scale type 2 diabetes efforts nationwide. The list of states includes:

- Maryland State Medical Society
- Pennsylvania Medical Society
- Mississippi State Medical Association
- Nebraska Medical Association
- Ohio State Medical Association
- Oregon Medical Association
- Massachusetts Medical Society
- Minnesota Medical Association
- Michigan State Medical Society
- South Carolina State Medical Association
- Medical Society of the State of New York

The AMA and American Diabetes Association (ADA) collaborated with Samsung, one of the world's leading electronics companies, to create a first-of-its-kind "mobile public awareness experience" during National Diabetes Awareness month in November 2017. Aimed at type 2 diabetes prevention, the goal of the collaboration was to help increase awareness among U.S. adults ages 18 to 60 about prediabetes as a condition, and to drive more individuals within this target population to assess their prediabetes risk via Samsung's "S-Health App" for monitoring physical and other health activities. During the month more than 340K adults completed the prediabetes risk assessment. Our public awareness campaign with the Ad Council, CDC and ADA through television, radio, and print has to date yielded another 560,000 risk test completions.

Advocacy

The AMA took a leading role in the successful fight to preserve access to affordable health care coverage for millions of Americans. Through our site patientsbeforepolitics.org, the AMA generated more than 7 million actions, including calls, emails, and social interactions that helped shape the debate on Capitol Hill.

The AMA blocked two insurance mega-mergers that effectively protected over $500 million in annual physicians' payments. The U.S. Court of Appeals in Washington, D.C., upheld the lower court's decision to block the Anthem-Cigna merger. The AMA filed an amicus brief in that case, in which the AMA argued (among many other key points) that the trial court properly found that Anthem's reimbursement cuts, rather than enhancing consumer welfare, could cause quality to degrade and consumers to be deprived of choice. Also, at the AMA's suggestion, the nation's experts on antitrust and competition submitted their own amicus brief that supported AMA's contention. On May 12, 2017, Anthem abandoned the Cigna merger.

The AMA secured retroactive changes to the Medicare legacy reporting requirements that will help physicians avoid $22 million in penalties in 2018, and addressed the biggest regulatory and administrative hurdles for physicians, including prior authorization, electronic health records, and insurer payment practices, such as new federal guidance that stops hidden transaction fees that could cost physician practices thousands of dollars per year.

The AMA secured more than 130 state legislative and regulatory victories on issues related to halting unfair health insurer practices, reversing the opioid epidemic, promoting medical liability reform, protecting Medicaid, and promoting team-based care/opposing inappropriate scope of practice expansions by non-physicians, as well as secured coverage for the Medicare Diabetes Prevention Program and for remote patient monitoring.

Health and Science

The AMA made progress on reversing the opioid epidemic. In 2017 the AMA was able to report fewer opioids being prescribed and an increase in prescription drug monitoring program use. The AMA continues its efforts to address the opioid epidemic by developing resources and advocating for policies intended to reduce opioid-related harm, increase access to effective treatment for pain, and broaden the base for accessing medication-assisted treatment for those suffering from opioid use disorder. A new opioid [microsite](#) was developed that contains a multitude of AMA and Federation-based resources addressing the intersection of pain, opioids, and addiction. Physicians are learning/following best practices for opioid prescribing. They continue, in increasing numbers, to access educational resources, register with and check patient information in prescription drug monitoring programs, obtain waivers for offering office-based treatment with buprenorphine, and co-prescribe naloxone for patients at risk of opioid overdose. Naloxone is now widely available for overdose interventions. Additionally, new partnerships were formed with hospitals, payers, government, and others in the public and private sector to work collaboratively to advance a public health solution to this enduring problem.

Health Solutions Group

In 2017 the AMA launched the Integrated Health Model Initiative (IHMI), a collaborative effort across health care and technology stakeholders that will unleash a new era of better, more effective patient care. IHMI supports a continuous learning environment to enable interoperable technology solutions and care models that will evolve with real-world use and feedback. IHMI uses the best available science to incorporate essential data elements around function, state, and patient goals. Key components of IHMI are: digital communities around costly and burdensome clinical areas, a physician-led validation process to review clinical applicability, and a data model for organizing and exchanging information. Since the public release in mid-October 2017, 1,000 individuals from 47 states and 33 countries have joined the IHMI platform, in addition to 17 collaborating organizations resulting in wide representation across external stakeholders.

In 2017 AMA Business Solutions, a subsidiary of the American Medical Association, collaborated with LexisNexis® Risk Solutions to create VerifyHCP™, a pre-populated physician data solution that aims to address the issue of inaccurate provider directories by streamlining verification and updates across participating health plans. VerifyHCP allows physicians to focus their resources on patient care and gives patients access to the credible information they need to make important health care decisions. A single interface with highly accurate pre-populated physician profile data allows for updates to all participating payer directories at one time. The solution reduces the administrative burden on physicians and helps patients access more accurate directories when selecting physicians.

The AMA in 2017 also established the Digital Medicine Payment Advisory Group, a collective of clinical and technical subject matter experts with years of hands-on experience integrating digital medicine services and tools into clinical practice to provide leadership in digital medicine adoption. This initiative will help open access to high-

quality and safe clinical care for patients and their physicians that promote improved health outcomes. The group has identified payment and coverage strategies—with an initial emphasis on coding, coverage, and payment for remote patient monitoring services—to help overcome existing barriers to adoption. This group of 14 experts has been working as a cohesive group for more than a year with clear goals and objectives set for 2018 and beyond.

JAMA/JAMA Network

JAMA and the JAMA Network continue to expand the amount of content produced, the formats for distribution, the audiences they engage, and the impact their content has on research and practice. In 2017, *JAMA* users viewed full-text content over 31 million times and downloaded and listened to over 2 million podcasts. Downloads across the JAMA Network are up significantly as well, with over 70 million full-text views in 2017. *JAMA's* impact factor rose to 44.4, and *JAMA Oncology* debuted with an impact factor of 16.6. Finally, in October, the JAMA Network announced the launch of JAMA Network Open, an open access journal that launched in 2018.

Communications

The AMA played a central role in health system reform by clearly and firmly articulating a positive vision for bipartisan reform, and by calling attention to the deficiencies in the various proposals that came through Congress. The AMA commanded attention as demonstrated by a nearly 50 percent share of voice of media coverage among its advocacy peers. The AMA was referenced more often—and by more media publications, broadcasts, and blogs—than *any* other health care organization in 2017, earning nearly 33 billion media impressions, which is more than on any other single issue in AMA history.

The AMA unveiled a bold brand campaign, the first in more than a decade, that in a brief timeframe helped change perceptions of the AMA among students, residents, and physicians and paved the way for the introduction of an ambitious membership campaign.

Physician Engagement

Physician Engagement: AMA launched the new "Membership Moves Medicine™" campaign, a multi-channel effort to educate prospective and existing members about AMA's activities and accomplishments on behalf of patients and physicians—and provide tangible and compelling reasons to join the AMA. It also launched a digital communities pilot program (with nearly 4,000 initial participants across three main communities: IMGs, Medical Students, Physician—Reinventing Medical Practice) and the initial version of the Ambassador Program that leverages nearly 1,000 AMA council and section leaders to represent the AMA online, in social forums, and at live events.

Digital Transformation: The AMA launched more than 15 new areas on the AMA website, including a new House of Delegates/Annual Meeting site. The AMA revised the digital marketing platform with new landing pages, sign-up process, and account management center, greatly improving membership conversion rates. The website updates include five new thematically driven destinations that combine news storytelling and aggregated high-value content on subjects that connect with audiences for impact and engagement (i.e., compelling stories, research, tools, and resources to show the AMA's impact and how members move medicine).

Membership: In 2017 the AMA saw its seventh consecutive year of membership growth, a 1.8 percent increase in dues paying members over 2016, and maintained a strong retention rate of nearly 82 percent.

Resident Program: The AMA launched the new GCEP Resident Education Platform (formerly known as the "Introduction to the Practice of Medicine"). By converging the strategic goals of Physician Engagement, the Education Center (EC), and ACE, the AMA was able to improve significantly on the former program's appeal and performance. The new platform advances AMA content offerings and encourages frequent engagement; it provides opportunity to extend and expand programming at the UME, GME, and CME levels; and it drives lifelong affiliation and membership with the AMA.

EVP Compensation

During 2017, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,053,515 in salary and $987,735 in incentive compensation, reduced by

$5,114 in pre-tax deductions. Other taxable amounts per the contract are as follows: $14,478 imputed costs for life insurance, $7,620 imputed costs for executive life insurance, $2,500 paid for health club fees, $2,880 paid for parking and $3,500 paid for a physical. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the "AMA 2017 Annual Report."

8. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2017 THROUGH FEBRUARY 2018

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2017 through February 2018 and is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE IN THE UNITED STATES: CDC MORBIDITY AND MORTALITY
  WEEKLY REPORTS (MMWR)

According to the Centers for Disease Control and Prevention (CDC) tobacco use remains the leading preventable cause of disease and death in the United States with an estimated 480,000 premature deaths annually, including more than 41,000 deaths resulting from secondhand smoke exposure. These data translate to about one in five deaths related to tobacco use annually, or 1,300 deaths every day. From March 2017 through February 2018, the CDC released 13 MMWRs related to tobacco use. These reports provide useful data that researchers, health departments, community organizations and others use to assess and develop ongoing evidence-based programs, policies and interventions to eliminate and/or prevent the economic and social costs of tobacco use.

2017:
https://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2017/index.htm

2018
https://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2018/index.htm

Youth Smoking Rates and Trends

According to the June 16, 2017 MMWR, which was an analysis of data from the 2011-2016 National Youth Tobacco Surveys (NYTS), there were substantial increases in electronic cigarette (e-cigarette) and hookah use among high school and middle school students, whereas significant decreases were observed in the use of cigarettes, cigars, smokeless tobacco, pipe tobacco, and bidis. The NYTS is a cross-sectional, voluntary, school-based, pencil-and-paper questionnaire self-administered to U.S. middle and high school students. A three-stage cluster sampling procedure was used to generate a nationally representative sample of U.S. students attending public and private schools in grades 6–12.

Specifically among all high school students, current use of any tobacco product did not change significantly from 2011 (24.2%) to 2016 (20.2%); however, there was a significant decrease in current use of any combustible tobacco product (21.8% to 13.8%). The use of e-cigarettes increased from 1.5% to 11.3% during this same period.

In 2016, among youth tobacco products users, 47.2% of high school students and 42.4% of middle school students used 2 or more tobacco products. E-cigarettes were the most commonly used tobacco product among high school (11.3%) and middle school (4.3%) students.

The authors highlight the need for sustained efforts to implement proven tobacco control policies and strategies that are critical to preventing youth use of all tobacco products. There is concern about the rising popularity of e-cigarettes. The FDA deeming rule that went into effect in August 2016, gives FDA jurisdiction over products made

or derived from tobacco, including e-cigarettes, cigars, pipe tobacco and hookah tobacco. This oversight could reduce youth tobacco product initiation and use if combined with other environmental strategies such as taxes and raising the purchase age to 21.

Adult Smoking Rates

To assess progress toward the *Healthy People 2020* target of reducing the proportion of U.S. adults aged 18 years and older who smoke cigarettes to12.0% or lower, the January 19, 2018 MMWR analyzed data from the 2016 National Health Interview Survey (NHIS). The NHIS is an annual, nationally representative in-person survey of the noninstitutionalized U.S. civilian population. The NHIS core questionnaire is administered to a randomly selected adult in the household (the sample adult).

In 2016, the prevalence of current cigarette smoking among adults was 15.5%, which was a significant decline from 2005 (20.9%); however, no significant change has occurred since 2015 (15.1%). Current cigarette smoking prevalence was higher among males (17.5%) than among females (13.5%). By age group, prevalence was higher among adults aged 25–44 years (17.6%) and lower in adults 65 and older (8.8%).

Veterans Smoke at Higher Rates

The January 12, 2018 MMWR looked at tobacco use among military veterans in the U.S. from 2010-2015. An estimated 30% of veterans reported tobacco use and among those, 7% reported use of two or more tobacco products. Cigarettes were the most commonly used tobacco product (21.6%), followed by cigars (6.2%), smokeless tobacco (5.2%), roll-your-own tobacco (3.0%), and pipes (1.5%). Within subgroups of veterans, current use of any of the assessed tobacco products was higher among persons aged 18–25 years (56.8%), Hispanics (34.0%), or persons with less than a high school diploma (37.9%).

The authors highlighted the significant impact of tobacco use among veterans on healthcare costs. During 2010, the Veterans Health Administration (VHA) spent an estimated $2.7 billion on smoking-related ambulatory care, prescription drugs, hospitalization, and home health care for the segment of the veteran population receiving VHA services. Tobacco use among active military personnel can eventually contribute to VHA expenditures. Reducing tobacco use among both active duty military and veterans can therefore result in a substantial reduction in tobacco-related morbidity and mortality and billions of dollars in savings from averted medical costs.

Recommendations to address the high rates of tobacco use in veterans include promoting cessation to current military personnel and veterans, implementing tobacco-free policies at military installations and Veterans Affairs medical centers and clinics, increasing the age requirement to buy tobacco on military bases to 21 years, and eliminating tobacco product discounts through military retailers.

AMA TOBACCO CONTROL ACTIVITIES

AMA Calls on Walgreens to Stop Selling Cigarettes

According to an online survey, 82% of Walgreens' shoppers surveyed agreed that "the primary focus of stores with pharmacies should be to sell products that help people get and stay healthy" and 73% reported that they favor a ban on tobacco sales at Walgreens. The survey was conducted by the Truth Initiative, a national nonprofit focused on eliminating tobacco use through youth engagement research and education.

The survey results were highlighted in a joint letter (January 2018) signed by the AMA and other medical and health groups calling on Walgreens to discontinue sales of tobacco products. The letter to the Walgreens Chief Medical Officer cited research that confirms that retail marketing, in-store advertising, and displays are associated with compromising quit attempts and cause the initiation and progression of tobacco use among young people. The letter also called on Walgreens to:

- refrain from opposing policies that reduce tobacco use including those that require tobacco-free retailers and regulate retail licensing and density;
- eliminate sales of tobacco products while continuing to sell FDA approved nicotine therapies; and
- employ pharmacy-based plans to assist smokers with quit attempts including cessation counseling.

The AMA opposed sales of tobacco products in pharmacies as early as 2003. As stated in the Board of Trustees Report 02-I-03, "Opposition to Sales of Tobacco in Pharmacies", the sale of tobacco products in pharmacies presents an ethical conflict for pharmacists; sends unhealthy, mixed messages to consumers about the role of pharmacies in the community; is not a clear economic necessity; and negatively affects the health of our patients. By selling and promoting tobacco, pharmacies undermine the tobacco control efforts of the rest of the health community.

AMA first adopted its policy calling for a ban on sales of tobacco products in pharmacies in 2009 and reaffirmed Policy D-495.994, in 2013.

Declines in Smoking in Movies Stalled since 2010

In response to the July 7, 2017, MMWR, Tobacco Use in Top-Grossing Movies - United States, 2010–2016, the AMA signed on to a letter to film industry leaders demanding that movie producers, distributors and exhibitors apply an R-rating to all films that include depictions of smoking or tobacco. According to the MMWR, the average number of tobacco incidents increased 55% in youth-rated movies with any tobacco depiction from 22 incidents in 2010 to 34 incidents in 2016. Previous studies had shown a steady decline, and if that trend had continued, all youth-rated films would have been smoke-free by 2015.

The AMA was one of several organizations, including the American Academy of Pediatrics, American College of Physicians, American Heart Association, American Lung Association, American Public Health Association and others, who signed the letter citing the report. The medical and public health groups set a deadline of June 1, 2018 for the industry to end its practice of using tobacco depictions in youth-rated movies because research has shown these images have a direct impact on children. In a press statement, AMA President Dr. David O. Barbe said "We urge the motion picture industry to listen to the collective plea of the nation's physicians and once and for all apply an 'R' rating to films depicting cigarette smoking to help keep lethal, addictive tobacco products out of the hands of young people. We will continue to advocate for more stringent policies and support efforts to protect our nation's youth from the dangers caused by tobacco use."

AMA House of Delegates Continues to Support Strong Tobacco Control Policies

The AMA House of Delegates adopted new or modified existing tobacco control policies at its 2017 Annual Meeting and 2017 Interim Meeting. Among the policies adopted was H-490.905, "Use of Tobacco Industry-Sponsored Cessation and Prevention Materials," which called on physicians to use smoking cessation materials from credible sources when talking with their patients. Physicians and health organizations are urged to avoid providing to patients and consumers information or materials on tobacco cessation that come from tobacco companies or other groups aligned with the tobacco industry.

The AMA also adopted D-490.974, "Corrective Statements Ordered to be Published by Tobacco Companies for the Violation of the Racketeer Influenced and Corrupt Organizations Act," that calls for educating the public and policymakers about the organized conspiracy of several tobacco companies to commit fraud and mislead consumers about the negative health effects of tobacco use. In 2006, several tobacco companies were found in violation of the U.S. Racketeer Influenced and Corrupt Organizations (RICO) Act. Ten years after that decision, the U.S. Court of Appeals finalized the content of the corrective statements the companies are required to make public.

Under this policy, the AMA will work with state and medical specialty societies as well as public health organizations to increase public awareness of the tobacco companies that were found in violation of the RICO Act and the corrective statements that they are being required to publish. The policy also encourages state and medical specialty societies to work with appropriate public health organizations in their states to help identify public policies that may have been directly or indirectly influenced by tobacco companies, and encourage lawmakers to reject any potential tobacco industry influences on future policy.

AMA Fights for Tobacco Provisions in Appropriations Bill

The AMA joined with medical groups and health organizations to oppose the House Agriculture, Rural Development, Food and Drug Administration (FDA), and Related Agencies appropriations bill. The bill called for weakening the FDA's authority over certain tobacco products and would exempt the Agency's oversight over large

and premium cigars entirely. This bill was of particular concern because it would have created a loophole that would enable manufacturers of some cheap, fruit- and candy-flavored cigars to escape from FDA oversight and prevent FDA from implementing common sense rules for all cigars.

A 2009 law requires FDA review of new or changed tobacco products and applies to new products introduced after February 15, 2007. This review is critical to stop tobacco companies from introducing products that are more appealing to children, more addictive and even more harmful.

The House appropriations language would completely exempt from this requirement any e-cigarettes or cigars that are already on the market. Exempted products would include cigars and e-cigarettes in an array of candy and fruit flavors that clearly appeal to children. The proposed language would allow these products to stay on the market without any FDA review to determine whether they attract children or otherwise harm public health.

The advocacy efforts by the medical and health groups were successful. In March 2018, the House policy riders to exempt "large and premium cigars" from FDA oversight and to change the "grandfather date" in order to exempt e-cigarettes, cigars, and other tobacco products from an FDA product review requirement were not included in the final bill.

9. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2008 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
                   REMAINDER OF REPORT FILED**

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110, "Sunset Mechanism for AMA Policy"). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA councils as a guide, the staffs of the AMA councils determine which policies should be reviewed by which councils.
- For the Annual Meeting of the House, each council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

In this report, the Board of Trustees presents recommendations from the Council on Legislation on the disposition of the House policies that were assigned to it. The Council's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX 1 - Recommended Actions on 2008 House Policies

Policy Number	Title	Text	Recommendation
H-180.972	Increased Third Party Payer Accountability	The AMA will include in its legislative and/or public relations programs the goal of putting an end to inflammatory language contained in third party payer notifications to patients. Citation: (Res. 235, A-92; Reaffirmed: Sub. Res. 106, I-98; Reaffirmation I-98; Reaffirmed: CLRPD Rep. 1, A-08)	Retain — policy remains relevant.
H-245.971	Home Deliveries	Our AMA: (1) supports the recent American College of Obstetricians and Gynecologists (ACOG) statement that "the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers"; and (2) supports state legislation that helps ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the AAP and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers. Citation: (Res. 205, A-08)	Retain — policy remains relevant.
H-270.957	FTC Identification Theft Prevention Programs	Our AMA is commended for its efforts to eliminate physicians under the definition of 'creditors' as currently interpreted by the Federal Trade Commission (FTC) in its rules implementing the Fair and Accurate Credit Transaction Act of 2003, and will continue its vigorous advocacy opposing the FTC's efforts to include physicians as creditors under the FACTA 2003. Citation: Res. 222, I-08	Retain — policy remains relevant.
H-270.965	Physician-Assisted Suicide	Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer. Citation: (Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08)	Retain — policy remains relevant.
H-315.977	Abuse of the Medical Record for Regulation or Financing the Practice of Medicine	(1) Our AMA continues to oppose the use of the physician office medical record as a tool of CMS, as well as any other agency or third party, to regulate the financing and practice of medicine. (2) The medical record shall be the property of the physician and the information contained therein, the property of the patient. (3) The physician's office medical record should be used solely to document the delivery of health care. Citation: (Res. 820, A-99; Reaffirmation I-08)	Retain.

H-330.893	Medicare Election Period	AMA policy is that physicians should be given the option of a Medicare semi-annual participation election period occurring at the end and the middle of the calendar year. Our AMA will petition the Centers for Medicare & Medicaid Services to permit a semi-annual participation election period occurring at the end and the middle of the calendar year. Citation: (Res. 216, I-08)	Retain — policy remains relevant.
H-335.963	Member Education on Medicare Recovery Audit Contractors	Our AMA: (1) will educate our membership about the effect of the program's safeguard contractor activity and Recovery Audit Contractor (RAC) audits on individual physician practices, expansion of the RAC program, and assistance that may be available through our AMA; and (2) will actively support the legislation currently before Congress to require an immediate moratorium on the expansion of the RAC program, and will seek the introduction of subsequent legislation that would limit or exclude physician billings from the authority of RAC audits altogether. Citation: (Sub. Res. 226, A-08)	Retain — policy remains relevant.
H-350.961	Improving the Health of Minority Populations	Our AMA urges Congress to re-evaluate and expand the federal race and ethnicity categories to include additional ethnic subgroups in order to analyze and uncover racial and ethnic health and healthcare disparities. Citation: (Res. 906, I-08)	Rescind — this policy is no longer relevant. The U.S. Department of Health and Human Services does include multiple ethnic subgroups with respect to Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status.
H-360.998	Cardiac Resuscitation by Nurses	With the intent of promoting good patient care, the AMA recognizes the propriety of registered nurses using monitoring, defibrillation, and resuscitative equipment, and instituting immediate life-saving corrective measures, if a licensed physician is not immediately available to do so, providing that: (1) The techniques to be used by a registered nurse in a hospital setting shall have been specified for the hospital by the medical staff on the basis of counsel by a committee representing authoritative medical and nursing opinion; (2) The registered nurse has been competently instructed in the techniques to be used; and (3) The registered nurse performs the authorized procedures: (a) upon the direct order of a doctor of medicine, or (b) pursuant to standing procedures established by the medical staff, these procedures to include provision for immediate summoning of a physician and such other personnel as may be needed. Citation: (Res. 42, I-67; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)	Retain — policy remains relevant.
H-375.983	Appropriate Peer Review Procedures	(1) Our AMA urges state medical associations to investigate applicable state law to determine if additional state agency supervision of peer review is needed to meet the active state supervision requirement set forth by the Supreme Court. (2) Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity: (a) In any situation where it appears that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the	Retain — policy remains relevant.

physician's medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought. The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization and the medical staff should each have separate legal counsel. The attorney of the body bringing the peer review action, be it the health care organization or the medical staff, should undertake the procedures needed to prepare for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. This health care organization or medical staff attorney should be instructed that his or her role includes assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The attorney for the body which is not bringing the peer review action should work to ensure that proper peer review processes as outlined in the medical staff bylaws are followed. The role of the attorney for the accused physician is solely to defend his or her client.

(b) The medical executive committee, through its attorney, may consult with the health care organization, through its attorney, regarding appointment of a hearing officer. If an attorney is sought to be the hearing officer, those solo attorneys or attorneys from a firm regularly used by the hospital, medical staff, or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities, should not be eligible to serve as hearing officers. The hearing officer shall gain no direct financial benefit from the outcome.

(c) The attorney advising the medical staff or, in the limited situation where the hospital is prosecuting the correction action, the attorney advising the health care organization, and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing officer.

(d) Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and at the discretion of the hearing officer.

(e) A court reporter should be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the court report shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it.

(f) Within the discretion of the hearing officer, witnesses may be requested to testify under oath.

(g) The role of the hearing panel should be defined in the medical staff bylaws. The role of the hearing panel may include, without being limited to, such duties as: acting as an objective arbiter of evidence, examining witnesses, determining adherence to the standard of care, providing well-reasoned documented opinions and decisions, and other duties noted herein. The hearing panel should only consist of physicians, none of whom are direct economic competitors with the physician involved or who stand to gain through a recommendation or decision adverse to the physician. It is desirable that members of the hearing

		panel be physicians who have the respect of the medical community, and should include a fair representation of the same specialists/subspecialist physicians as the physician involved, whenever feasible. (h) Physicians serving on the hearing panel should receive information and training in the elements and essentials of peer review. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. Wherever feasible, data collection and analysis, or similar assessment instruments, and multiple reviewers should be used to increase reliability in evaluating whether peer review disciplinary proceedings are warranted. Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustments. (i) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the health care organization, but a physician should not be deprived of his or her privileges solely on the basis of medical testimony by economic competitors. In any proceedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based. (j) The hearing panel should credit the evidence brought before it in a manner reflective of the specificity of the evidence and the personal or economic biases of witnesses. (k) When investigation is underway and indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a physician's hospital privileges, he or she should be notified that resignation will result in a report to the National Practitioner Data Bank. Citation: (BOT Rep. MMM, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05; Amended with change in title: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmation A-08)	
H-383.999	~~Formation of a National Negotiating Organization~~ <u>Physician Negotiation</u>	(1) All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs; ~~(2) Our AMA immediately implement a national labor organization under the National Labor Relations Act to support the development and operation of local negotiating units as an option for employed physicians;~~ ~~(3) Our AMA immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to collectively bargain;~~ (4<u>2</u>) Our AMA continue to support the development of independent house staff organizations for <u>employed,</u> resident and fellow physicians and ~~be prepared to implement a national labor organization to~~ support the development and operation of local negotiating units as an	Retain in part, with change in Title — some sections of this policy are no longer relevant or have been achieved or are addressed in other AMA policy.

		option for all <u>employed,</u> resident and fellow physicians ~~at such time as the National Labor Relations Board determines that resident and fellow physicians are~~ authorized to organize labor organizations under the National Labor Relations Act; ~~(5) Our AMA continue to vigorously support antitrust relief for physicians and medical groups by actively supporting federal legislation consistent with the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304 introduced by Representative Tom Campbell, R-CA and John Conyers, D-MI), aggressively working with the Department of Justice and the Federal Trade Commission, and continue providing model legislation and information on the state-action doctrine to state medical associations and members; (6) Our AMA be prepared to immediately implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups when the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304)~~ become law; <u>and</u> (7<u>3</u>) Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers~~;~~ ~~(8) That should the BOT determine that the Quality Health Care Coalition Act of 1999 (H. R. 1304) or similar legislation will not become law, our AMA immediately pursue the creation or adoption of new antitrust legislation to achieve the same goal; and (9) Our AMA, concurrent to proceeding with the establishment of any collective bargaining unit, undertake an extensive education program, directed at its member and non-member physicians, as to the possible limits on benefits and the risks to the formation of such a unit.~~ Citation: (Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08)	
H-390.852	Legislative Action to End Medicare SGR Problems	1. Our AMA, working with our state and specialty society colleagues, will pursue enactment of legislation that provides for at least two years of positive updates that accurately reflect the increases in costs of caring for Medicare beneficiaries and lays the groundwork for complete repeal in the near future. 2. The AMA's ultimate goal continues to be complete repeal of the SGR and its replacement with a fair and equitable payment system that adequately reflects increases in the cost of caring for Medicare beneficiaries. Citation: (BOT Rep. 31, A-07; Reaffirmation I-08)	Rescind — The Medicare Access and CHIP Reauthorization Act of 2015 replaced the SGR with new payment updates for physicians.
H-40.999	Medical Representation of Joint Chiefs of Staff	Under supervision of qualified medical officers of the three military services, medical representation is essential to effect coordination of the medical and health aspects of tactical, strategic and long range planning in the Joint Staff, the Combined Staff and the Special Command Staffs. Citation: (BOT Rep. L, I-59; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)	Retain — policy remains relevant.

H-410.956	Fairness and Quality in Medical Imaging Interpretation	Our AMA: (1) actively opposes efforts by federal and state legislators, regulatory bodies, private payers, public payers and radiology business management companies to preauthorize, precertify or otherwise restrict the application of advanced imaging services when such services are provided by qualified physicians in accordance with appropriateness guidelines, practice guidelines and technical standards for the imaging modalities utilized, as developed by specialty societies involved with the diagnosis and treatment of such patients; and (2) will actively work to ensure that all physician specialties involved in the care of patients with specific illnesses who need imaging services have equal participation and authority in the development of quality and efficiency measures for imaging services; and (3) will report back to the House of Delegates on an annual basis with details of actions AMA has taken to oppose efforts by private and public payers, radiology benefits managers and others to deny patients' access to appropriate, high quality imaging services provided by qualified physicians regardless of their medical specialty. Citation: (Sub. Res. 208, A-08)	Retain — policy remains relevant.
H-410.957	Intraoperative Neurophysiologic Monitoring	Our AMA policy is that supervision and interpretation of intraoperative neurophysiologic monitoring constitutes the practice of medicine, which can be delegated to non-physician personnel who are under the direct or online real time supervision of the operating surgeon or another physician trained in, or who has demonstrated competence in, neurophysiologic techniques and is available to interpret the studies and advise the surgeon during the surgical procedures. Citation: (Res. 201, A-08)	Retain — policy remains relevant.
H-420.958	Surgical Sterilization and Family PACT Eligibility	Our AMA supports a change in the Family Planning, Access, Care and Treatment (Family PACT) legislation, and the appropriate funding necessary, such that surgical sterilization shall not be a reason for exclusion from the Family PACT program. Citation: (Res. 210, A-08)	Retain — policy remains relevant.
H-435.948	Equality of Civil Liability Preemption for Physicians	Our AMA supports (1) efforts to grant physicians at least the same level of protection as manufacturers, whether by court decision or statute; and (2) state and federal legislation that addresses the civil liability of physicians who use FDA-approved devices and pharmaceuticals in a reasonable and prudent manner, so that physicians have at least the same level of protection offered the manufacturer for adverse events resulting from the use of said products. Citation: (Res. 201, I-08)	Retain — policy remains relevant.
H-435.950	Apologizing to Patients	AMA policy is that any statements by physicians of apology, confessions of regret, or admission of errors to patients and/or their families regarding less than anticipated clinical outcomes be subsequently inadmissible in court, and will seek to incorporate such policy into medical liability reform legislation. Citation: (Res. 217, A-07; Reaffirmation A-08)	Retain — policy remains relevant.
H-435.993	Tort Liability Reform	Our AMA: (1) supports the efforts of state medical societies to form coalitions supporting tort reform in each state and representing the numerous interests adversely affected by present escalating tort liability costs; and (2) believes these coalitions should address such issues as reform of laws governing product and professional liability, and development of appropriate public education	Retain — policy remains relevant.

		programs regarding the impact and cost to consumers of present liability laws. Citation: (Sub. Res. 6, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmation A-00; Reaffirmation I-08)	
H-440.863	Restoring the Independence of the Office of the US Surgeon General	Our AMA: (1) recognizes the Office of the United States Surgeon General as the esteemed position of the "nation's doctor;" and (2) calls for the Office of the United States Surgeon General to be free from the undue influence of politics, and be guided by science and the integrity of his/her role as a physician in fulfilling the highest calling to promote the health and welfare of all people. Citation: Sub. Res. 434; A-08	Retain — policy remains relevant.
H-510.989	Health Care for Veterans and Their Families	Our AMA supports the recommendations of the President's Commission on Care for America's Wounded Warriors report "Serve, Support, Simplify." Citation: (BOT Rep. 6, A-08)	Retain — policy remains relevant.
H-70.951	Medical Necessity Coding	(1) The AMA (a) immediately seeks both legislative and judicial relief from ~~ICD-9~~ICD-10 coding requirements for reimbursement of medical and laboratory services; and (b) supports only medical record review for medical necessity determinations, and then only when inappropriate or illegal behavior is suspected. (2) That until full implementation of this policy is achieved, our AMA seeks regulatory relief that would give physicians flexibility in assigning ~~ICD-9~~ICD-10 codes. (3) Our AMA advocates to all those private payers who do require ~~ICD-9~~ICD-10 codes for diagnostic studies that physicians should have the flexibility to assign any clinically appropriate diagnosis code. Citation: (Res. 806, I-97; Appended and Reaffirmed: Res. 816, I-98; Reaffirmed: CLRPD Rep. 1, A-08)	Retain, but update ICD-9 to ICD-10 — policy remains relevant.
D-160.946	Eliminating the Barriers to Surviving Acute Myocardial Infarction	Our AMA will: (1) work with relevant societies to conduct a thorough analysis of the geographic, economic and political barriers to optimal care for the ST-elevation myocardial infarction (STEMI) patient, e.g., the current environment, existing literature, the costs of ambulance ECG hardware, training and transmission; political issues of reimbursing one county for care provided to patients from another county or state, and the financial issues of shifting patients to centers that can perform preferred treatment algorithms; and (2) develop model legislation that would draw upon the successes of existing programs and the data garnered from a comprehensive environmental analysis, to identify workable solutions to breaking down the geographic, economic and political barriers to optimal care for the STEMI patient that currently exist. Citation: (Res. 529, A-08)	Retain — policy remains relevant.
D-165.946	Presidential Candidates' Views on Health System Reform	Our AMA will use its communications vehicles such as the AMA website, to publicize the health care positions of the major US Presidential candidates and encourage physicians to become more informed voters. Citation: BOT action in response to referred for decision Res. 603, I-07; Modified: Speakers Rep., A-15	Retain — policy remains relevant.
D-190.976	Internet Submissions of Medicare Claims	Our AMA: (1) will develop principles describing appropriate use of the Internet in submitting Medicare claims; and (2) supports the use of high speed Internet as a mechanism to file Medicare claims with appropriate safeguards that adhere to federal law and HIPAA standards to ensure the protection of patient health information. Citation: (Res. 836, I-08)	Retain — policy remains relevant.

D-330.925	Medicare Enrollment and Re-enrollment Delays	Our AMA will seek legislation mandating that the Centers for Medicare & Medicaid Services impose a requirement on its carriers and Medicare administrative contractors (MACs) that enrollment and re-enrollment applications must be processed within thirty days of receipt with appropriate feedback to the applicant, and that financial penalties be imposed on carriers and MACs for unjustified delays in enrollment and re-enrollment. Citation: (Res. 205, I-08)	Retain — policy remains relevant.
D-330.927	Medicare Advantage Program Budget Reduction	Our AMA will express our grave concerns to President Bush, the Executive Branch and Congress that a veto of legislation concerning a budget reduction in the Medicare Advantage Program with a corresponding increase in the Medicare Physician Fee Schedule would be an egregious error. Citation: (Res. 236, A-08)	Rescind — The Bush Administration is no longer in a position to veto this legislation, nor is it a current issue in Congress.
D-335.988	Audit Equity	Our AMA will seek relief from insurance inequity through legislation which instructs insurers to balance or refund for under-coding against any discovered over-coding during the course of an audit and not through extrapolation. Citation: (Res. 817, I-03; Reaffirmation A-08)	Retain — policy remains relevant.
D-35.989	Midwifery Scope of Practice and Licensure	Our AMA will: (1) only advocate in legislative and regulatory arenas for the licensing of midwives who are certified by the American College of Nurse-Midwives; (2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards; (3) continue to monitor state legislative activities regarding the licensure and scope of practice of midwives; and (4) work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives. Citation: (Res. 204, A-08)	Retain — policy remains relevant.
D-370.987	Study Incentives for Cadaveric Organ Donation	Our AMA will place high on its legislative agenda modification of the National Organ Transplantation Act to rescind prohibition of "valuable consideration" for cadaveric organ donation, so that pilot studies of financial incentives for donation can be carried out. Citation: (Res. 10, A-08)	Rescind — This policy has been superseded by H-370.958, Removing Disincentives and Studying The Use Of Incentives To Increase The National Organ Donor Pool.
D-383.989	Physician Freedom to Collectively Negotiate with Managed Care Plans and Health Insuring Organizations	Our AMA will: (1) increase the visibility of its campaign for antitrust relief for physicians, including specific strategies for accomplishing this goal; (2) prepare and distribute to its membership educational materials pertaining to current antitrust issues as it affects its members; (3) empower its members through these educational materials to embark upon a grassroots legislative campaign to secure antitrust relief for physicians when negotiating with third party payers; (4) speak forcefully to its membership that no member should feel compelled to sign any contractual agreement that harms his/her ability to provide compassionate and quality care to his/her patients; and (5) advance as part of its patient advocacy campaign that	Retain—policy remains relevant.

		physicians must have the right to enter into group discussions with managed care companies, exempt from antitrust violations, for the purpose of reducing the barriers to patient access and administrative burdens on physicians that delay patient care even if prohibited, by law, from discussing fees and reimbursement rates. Citation: (Sub. Res. 229, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-08)	
D-383.990	AMA's Aggressive Pursuit of Antitrust Reform	Our AMA will: (1) place a high priority on the level of support provided to AMA's Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws; (2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the "state action doctrine"; (3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers; (4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means; (5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and (6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans. Citation: (Res. 908, I-03; Reaffirmation, A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08)	Retain — policy remains relevant.
D-385.980	Provision of Payment Schedules and Methodology of Payment as Part of the Contracting Process	State medical associations that wish to pursue a ruling for their individual members similar to that used by the Medical Association of Georgia in obtaining relief from payment contract practices which do not disclose the full term of reimbursement should contact the Litigation Center for support. Our AMA, within its resources, should continue to assist physicians and medical associations that pursue well-grounded legal actions to secure disclosure from MCOs of their fee schedules and payment methodologies. Citation: (BOT Rep. 13, A-03; Reaffirmation A-08	Retain — policy remains relevant.
D-390.969	Parity in Medicare Reimbursement	Our AMA will continue its comprehensive advocacy campaign to: ~~(1) repeal the Medicare physician payment formula, the sustainable growth rate (SGR); (2~~1) repeal ~~or delay~~ the reductions in Medicare payment for imaging services furnished in physicians? offices, as mandated by the Deficit Reduction Act of 2005; (3~~2~~) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (4~~3~~) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and	Retain in part — The Medicare Access and CHIP Reauthorization Act of 2015 replaced the sustainable growth rate system with new payment updates, and the payment reductions from the Deficit Reduction Act have already taken place.

		gainsharing Citation: (BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-08)	
D-390.976	Medicare Physician Payment	Our AMA will send all members of Congress a letter, signed by all willing members of the Federation, urging them to enact legislation replacing Medicare's sustainable growth rate reimbursement formula with a system based on appropriate updates. Citation: (BOT Rep. 35, A-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation I-08)	Rescind — The Medicare Access and CHIP Reauthorization Act of 2015 replaced the sustainable growth rate system with new payment updates.
D-410.996	Physician Seeking Regulation of Physicians	Our AMA will, with the intent of improving patient care and promoting interspecialty collaboration, develop a process for national specialty groups to urge their state affiliates to work through the state medical association prior to the introduction of any state legislation that seeks to regulate or restrict the practice of other physician groups or specialties. Citation: (Res. 235, A-08)	Retain — policy remains relevant.
D-435.975	Blood Centers and Medical Liability	Our AMA will advocate that blood centers be covered under any health care liability reform legislation. Citation: (Res. 209, A-08)	Retain — policy remains relevant.
D-95.983	Mandatory Drug Screening Reporting	Our AMA will: (1) work with appropriate state and specialty medical societies and with state legislative bodies to ensure that physicians not be required to report patients with ~~positive~~ aberrant drug ~~screen~~ test results to the police; and (2) continue to promote education of physicians regarding the importance of referring patients found to have ~~positive~~ aberrant urine drug ~~screen~~ tests for appropriate medical treatment. Citation: (Res. 406, A-08)	Retain — policy remains relevant, but modify terms "positive" to "aberrant" and "drug screen" to "drug testing" and "drug tests" to reflect updated use of terms in this field. The original policy was written before drug monitoring was commonplace.

APPENDIX 2 - AMA Policies Superseding Policies Recommended for Rescission

Policy H-383.999, ~~Formation of a National Negotiating Organization~~ "Physician Negotiation"
(1) All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs;
~~(2) Our AMA immediately implement a national labor organization under the National Labor Relations Act to support the development and operation of local negotiating units as an option for employed physicians;~~
~~(3) Our AMA immediately implement a national labor organization to support the development and operation of local negotiating units as an option for resident and fellow physicians who are authorized under state laws to collectively bargain;~~
(4~~2~~) Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and ~~be prepared to implement a national labor organization to~~ support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians ~~at such time as the National Labor Relations Board determines that resident and fellow physicians are~~ authorized to organize labor organizations under the National Labor Relations Act;
~~(5) Our AMA continue to vigorously support antitrust relief for physicians and medical groups by actively supporting federal legislation consistent with the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304 introduced by Representative Tom Campbell, R-CA and John Conyers, D-MI), aggressively working with the Department of Justice and the Federal Trade Commission, and continue providing model legislation and information on the state action doctrine to state medical associations and members;~~
~~(6) Our AMA be prepared to immediately implement a national organization to support development and operation of local negotiating units as an option for self-employed physicians and medical groups when the current principles of the Quality Health Care Coalition Act of 1999 (H. R. 1304) become law;~~ and
(7~~3~~) Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers~~;~~
~~(8) That should the BOT determine that the Quality Health Care Coalition Act of 1999 (H. R. 1304) or similar legislation will not become law, our AMA immediately pursue the creation or adoption of new antitrust legislation to achieve the same goal; and~~
~~(9) Our AMA, concurrent to proceeding with the establishment of any collective bargaining unit, undertake an extensive~~

education program, directed at its member and non-member physicians, as to the possible limits on benefits and the risks to the formation of such a unit.
Citation: (Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08)

Policy D-383.990, "AMA's Aggressive Pursuit of Antitrust Reform"
Our AMA will: (1) place a high priority on the level of support provided to AMA's Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;
(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the "state action doctrine";
(3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers;
(4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means;
(5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and
(6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans. Res. 908, I-03 Reaffirmation, A-05 Reaffirmed: BOT Rep. 10, I-05 Reaffirmation A-06 Reaffirmation A-08

Policy H-385.973, "Collective Negotiations"
It is the policy of the AMA to seek amendments to the National Labor Relations Act and other appropriate federal antitrust laws to allow physicians to negotiate collectively with payers who have market power. Res. 95, A-90 Reaffirmed by BOT Rep. 33, A-96 Reaffirmation A-97 Reaffirmation I-98 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation A-01 Reaffirmation A-04 Reaffirmation A-05 Reaffirmation A-06 Reaffirmation A-08 Reaffirmation I-10 Reaffirmed: Res. 215, A-11 Reaffirmed: BOT action in response to referred for decision Res. 201, I-12

Policy D-370.987, "Study Incentives for Cadaveric Organ Donation"
Our AMA will place high on its legislative agenda modification of the National Organ Transplantation Act to rescind prohibition of "valuable consideration" for cadaveric organ donation, so that pilot studies of financial incentives for donation can be carried out. (Res. 10, A-08)

Policy H-370.958, "Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool"
1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation.
2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates.
3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. (Res. 7, I-15)

10. OVER-THE-COUNTER CONTRACEPTIVE DRUG ACCESS
(RESOLUTION 110-A-17)

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 110-A-17
REMAINDER OF REPORT FILED
See Policies H-180.958 and D-75.995

INTRODUCTION

At the 2017 Annual Meeting, Resolution 110-A-17, "Over-the-Counter Contraceptive Drug Access," introduced by the Illinois Delegation and referred by the House of Delegates (HOD), asked:

That our American Medical Association (AMA) condemn age-based, cost-based, and other non-medical barriers to contraceptive drug access;

That our AMA adopt policy supporting equitable access to over-the-counter (OTC) contraception, including those forms of contraception recommended for OTC sale, patient risk assessment screening tools, and prescribing by non-physicians;

That our AMA support policy solutions that prohibit cost-sharing obstacles to OTC contraceptive drug access, and full coverage of all contraception without regard to prescription or OTC utilization, since all contraception is essential preventive health care; and

That our AMA advocate for the legislative and/or regulatory mechanisms needed to achieve improvements for OTC contraceptive drug access and quality.

This report outlines the issues associated with OTC contraceptive drug access and provides a recommendation based on current evidence. Access to emergency contraception is not a focus of this report.

BACKGROUND

Unintended pregnancy is a major public health issue in the United States accounting for approximately 45% of all pregnancies and is associated with increased risks for negative outcomes for mothers and infants and increased health care costs.[1] Currently, OTC oral contraception is available in more than 100 countries. Although no OTC oral contraceptives are available in the United States, interest in their availability is high, with surveys finding that 62% of U.S. women support such access.[2]

Oral contraceptive pills consist of the hormones estrogen and/or progestin and are taken orally once per day. Three types are available in the United States: the combination pill with estrogen and progestin, the progestin-only pill, and the continuous use pill. The three types of oral contraceptives vary in their hormonal composition and the regimen for their use.[3] Emergency contraceptive pills, which consist of the progestin levonorgestrel, are also considered a type of oral contraceptive not intended for daily use, but that can be used to prevent pregnancy after unprotected sex.[3] Oral contraceptives are primarily used for pregnancy prevention, but they are also used to treat other health conditions such as menstrual pain, irregular menstruation, fibroids, endometriosis-related pain, menstrual-related migraines, and acne.[3]

Policy statements from the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and American Public Health Association (APHA) support OTC oral contraceptive access.[4-6] An Oral Contraceptives Over-the-Counter Working Group was formed in 2004 with the aims "to improve access to contraception and reduce disparities in reproductive health outcomes by making a low-cost oral contraceptive product available OTC in the United States." Over 80 organizations have signed onto the Working Group's statement of purpose, including the American Academy of Pediatrics and ACOG.[7]

A variety of concerns have been raised in discussions of OTC oral contraceptives, including barriers to access, cost of a potential OTC oral contraceptive, and safety, which are briefly discussed below.

BARRIERS TO CONTRACEPTIVE USE

One third of women at risk for unintended pregnancy who attempted to obtain a prescription for contraception reported having trouble doing so.[8] Access and cost issues are the most commonly cited reasons why women do not use oral contraceptives, use them inconsistently, or discontinue use early. Women may experience difficulty obtaining oral contraceptives for a variety of reasons including the prescription requirement, lack of insurance, and inaccessibility when travelling. Research suggests that OTC access would increase the use of contraception and facilitate continuity of use.[9] Additional time and cost benefits include less travel, fewer physician office visits, and less time off work.

INSURANCE COVERAGE AND ACCESS

Under the Patient Protection and Affordable Care Act (ACA), most private health insurance plans are required to provide coverage for at least one product in each of the 18 contraceptive methods approved by the U.S. Food and Drug Administration (FDA) for women with no cost-sharing.[10] This coverage also applies to OTC contraceptives used by women, such as emergency contraception, barrier methods, and spermicide, but a prescription is required.[11]

Plans are not required to cover male contraception methods such as vasectomy and male condoms. Federal law requires Medicaid programs to cover family planning services and supplies without cost-sharing. States that expanded Medicaid under the ACA must follow the ACA requirements for oral contraceptives. Coverage for oral contraceptives is required in the Indian Health Service and in the TRICARE program, but is not a requirement for Medicare. Regulations exist to exclude some or all contraceptive methods and services from health plans provided by employers who morally object to oral contraceptive use or have religious exemptions. However, enforcement of these regulations has been blocked by the courts.

Cost is an important consideration. A survey of U.S. women indicated that the maximum they are willing to pay for an OTC oral contraceptive is $20.[2] A cost modeling analysis determined that full insurance coverage of an OTC oral contraceptive without any out-of-pocket expenses would result in the largest reduction of unintended pregnancies.[12] The analysis also found that use would be highest, and the estimated reduction in unintended pregnancy greatest, among low-income women, if an OTC oral contraceptive was fully covered by insurance with no cost-sharing. Full coverage would also be cost effective for insurers because of the savings associated with averting unintended pregnancies.[12] AAFP, ACOG, and APHA policy statements include support for insurance coverage of OTC contraceptive products without the need for a prescription. Federal or state legislative or administrative changes to ACA policy would be needed to include non-prescribed contraceptives in coverage and pharmacies would need billing mechanisms for processing claims without a prescription. Billing mechanisms that do not rely on a prescription are used by Medicaid programs in several states to cover OTC emergency contraception. These billing mechanisms have been incorporated into existing software, and it may be feasible for additional insurers to incorporate the ability to process claims without a prescription. Computerized kiosks providing a prescription for contraception after the completion of a self-screening tool are currently being piloted, and the potential exists for women to be able to generate a prescription in a pharmacy or at home using web-based tools from insurers.[13] Congress has introduced legislation addressing this issue, and a few states have passed laws requiring insurers to cover OTC contraceptives without a prescription.[3]

Concerns have been raised that overall access to oral contraceptives may be hindered if an OTC product becomes available and the switch negatively affects insurance coverage for other prescription oral contraceptives or creates new barriers to obtaining these products.[13] Insurers may employ formulary management strategies such as preferred drug lists, prior authorization, and step-therapy programs.[13]

Some states allow pharmacists to provide oral contraceptives without physician oversight. Policies in such states vary including age requirements, type of contraceptive allowed, and length of supply. Some discussion has centered around the issue of increasing the dispensing period of oral contraceptives to a 12-month supply to facilitate access. Dispensing requirements vary by insurer and laws requiring coverage for a 12-month supply have been passed in several states.[3] Additionally, online services and smartphone applications have emerged for women to speak with providers via video, obtain prescriptions, and order oral contraceptives from mail delivery services. Requirements and cost vary based on the application.[3]

SELF-SCREENING

In 2016, the U.S. Centers for Disease Control and Prevention (CDC) published an updated Medical Eligibility Criteria for Contraceptive Use (U.S. MEC), an evidence-based list of conditions and medications considered contraindications to contraceptive methods. The U.S. MEC states that all contraindications for combined oral contraceptives, other than hypertension, can be identified by reviewing a woman's medical history; progestin-only oral contraceptives have a shorter list of contraindications that does not include hypertension.[1,14]

Concern has been raised from physicians that women might not be able to self-diagnose contraindications associated with oral contraceptives or may ignore label warnings. Studies have shown that women can accurately use checklists to determine if they have contraindications to hormonal contraception; in one study, 96% of cases evaluated demonstrated agreement between a women's assessment of her contraindications using a checklist and a clinician's independent evaluation, and women often take a more conservative approach compared with clinicians.[15,16]

Another concern that has been voiced about OTC oral contraceptives is that women would not obtain recommended preventive screenings for cervical and breast cancer and for sexually transmitted infections that often accompany physician visits for contraceptives. The World Health Organization, FDA, and ACOG state that oral contraceptives can be safely and effectively prescribed without a pelvic examination. Although experts have stated that that

preventive screening is not medically necessary or required for the provision of hormonal contraception,[17] many clinicians continue to link the services.[18] A recent study found that a high proportion of women in Texas who acquired oral contraceptives from Mexico without a prescription obtained screening tests at a rate higher than the U.S. national average.[19]

AGE RESTRICTIONS

Adolescents face age-related barriers to contraception access, which could be reduced with OTC access, including concerns about disclosing their confidential information and their ability to access services without the consent of a parent or guardian. An age restriction for an OTC product is uncommon, but is a relevant topic related to OTC oral contraceptives. Some states that allow pharmacists to provide oral contraceptives include age restrictions in their policy. When levonorgestrel emergency contraception became available OTC, there was an age restriction that was later removed. The consensus is that oral contraceptives are safe and the prevalence of contraindications is greater in women 35 years and older compared to younger users and is low among women of all ages for a progestin-only product.[5,15]

A 2011 survey revealed that most women do not support an age restriction for oral contraceptives and a survey of teenagers found that approximately three-quarters supported oral contraceptive OTC access.[8,20] Additionally, studies showed that sexual risk-taking behaviors did not increase in teenagers when their access to emergency contraception increased, and the increased access may aid in improving their use of more effective contraception methods.[21]

FDA APPROVAL PATHWAY

The FDA has pathways in place for the development and regulation of OTC products, the monograph process or the New Drug Application (NDA) process. Products for which an OTC monograph does not exist or that do not conform to an existing final monograph, as is the case for oral contraceptives, primarily use the NDA process. A sponsor seeking to market a product OTC, either as a new NDA or a switch from a prescription product, applies to the Division of Nonprescription Drug Products in the Office of Drug Evaluation IV.[22]

Once a sponsor submits an NDA to change one oral contraceptive product that is already registered as a prescription product to an OTC product, there are consumer studies, safety data evaluations, and regulatory reviews required by the FDA. The required information includes the following:

- Post-market safety data review: Toxicity data, addictive properties, and interactions with other drugs are evaluated to establish the safety of the medication as a prescription product.
- Label comprehension study: Ability of potential users to understand OTC labeling of medication and take the medication as indicated without a physician's explanation are evaluated.
- Self-selection study: Ability of potential users to determine whether the product is appropriate for them is evaluated.
- Actual use study: Correct use of the product by potential users in a simulated OTC environment is evaluated.
- Human factors study: Interacting with the product by potential users is evaluated.

Following collection and submission of data, FDA staff reviews and evaluates the findings in consultation with an advisory committee. Many of the required studies can occur simultaneously; however, this process can take three to four years from NDA initiation until an application is approved. Evidence published in peer-reviewed literatures suggests that oral contraceptives generally meet FDA requirements for an OTC switch.[23]

Over fifty formulations, accounting for hundreds of different branded products of oral contraceptives, exist as prescription medications. Only the specific product for which an NDA was submitted will be evaluated for OTC sale. All others would remain as prescription medications unless an NDA or Abbreviated New Drug Application (ANDA), in the case of a generic with the same drug formulation, is submitted and required studies are individually performed for each one.

Progestin-only oral contraceptives have fewer and more rare contraindications than combined oral contraceptives, which may make them a better candidate for FDA approval for OTC sale. A progestin-only product has been put forward as a potential first candidate for an OTC oral contraceptive. In December 2016, Ibis Reproductive Health announced a partnership with HRA Pharma to conduct the research needed and submit an application to the FDA to

bring a progestin-only oral contraceptive pill to the Unites States OTC market.[24] The 2006 FDA approval of OTC sale for progestin-only levonorgestrel emergency contraception, which contains a higher dose of progestin than is found in oral contraceptives, may make it easier to obtain approval for an OTC progestin-only product than for a combined oral contraceptive product.[13]

CURRENT AMA POLICY

Several current AMA policies address contraceptives. Policy D-75.995, "Over-the-Counter Access to Oral Contraceptives," directs our AMA to recommend to the FDA that manufacturers of oral contraceptives be encouraged to submit the required application and supporting evidence for the Agency to consider approving a switch in status from prescription to OTC for such products and encourages the continued study of issues relevant to over-the-counter access for oral contraceptives. Policy H-75.990, "Development and Approval of New Contraceptives," encourages manufacturers to conduct post-marketing surveillance studies of contraceptive products. Policy H-75.998, "Opposition to HHS Regulations on Contraceptive Services for Minors," opposes regulations that require parental notification when prescription contraceptives are provided to minors through federally funded programs, since they create a breach of confidentiality in the physician-patient relationship. Policy H-180.958, "Coverage of Prescription Contraceptives by Insurance," supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives. Policy H-75.987, "Reducing Unintended Pregnancy," urges health care professionals to provide care, assistance, and education for women of reproductive age, supports reducing unintended pregnancies as a national goal, and supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling. Policies H-75.985, "Access to Emergency Contraception," and D-75.997, "Access to Emergency Contraception," support the access to emergency contraception.

CONCLUSION

An FDA pathway exists for the conversion of prescription products, such as oral contraceptives, to OTC products if manufacturers submit the required application and data. A potential first candidate for an OTC progestin-only oral contraceptive product was recently announced by a manufacturer because progestin-only products have fewer contraindications than other types of oral contraceptives.

Research has shown that women support the idea of OTC oral contraceptives and can effectively self-screen for their use. Additionally, removing the prescription access barrier to oral contraceptives would increase and facilitate continuity of use. Full insurance coverage, without cost sharing, of an OTC oral contraceptive would likely result in the largest reduction of unintended pregnancies as well as cost effectiveness for insurers. However, concerns regarding hindrance of overall access to oral contraceptives because of insurance formulary management strategies exist.

RECOMMENDATIONS

The Board of Trustees recommends the following be adopted in lieu of Resolution 110-A-17, and the remainder of the report be filed:

1. That our AMA amend Policy D-75.995, "Over-the-Counter Access to Oral Contraceptives;"

    D-75.995, Over-the-Counter Access to Oral Contraceptives
    Our AMA:
    1. ~~Our AMA~~ Encourages ~~will recommend to the US Food and Drug Administration that~~ manufacturers of oral contraceptives ~~be encouraged~~ to submit the required application and supporting evidence to the US Food and Drug Administration for the Agency to consider approving a switch in status from prescription to over-the-counter for such products.
    2. ~~Our AMA~~ Encourages the continued study of issues relevant to over-the-counter access for oral contraceptives.

2. That our AMA amend Policy H-180.958, "Coverage of Prescription Contraceptives by Insurance;"

   H-180.958, Coverage of ~~Prescription~~ Contraceptives by Insurance
   1. <u>Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.</u>
   2. <u>Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care.</u>

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**11. HOUSING PROVISION AND SOCIAL SUPPORT TO IMMEDIATELY ALLEVIATE
CHRONIC HOMELESSNESS IN THE UNITED STATES
(RESOLUTION 208-A-17)**

Reference committee hearing: see report of Reference Committee D.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
                   IN LIEU OF RESOLUTION 208-A-17
                   REMAINDER OF REPORT FILED**
                   See Policy H-160.903

INTRODUCTION

Resolution 208-A-17, "Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States," introduced by the Medical Student Section (MSS) and referred by the House of Delegates (HOD) asked that our AMA amend Policy H-160.903, "Eradicating Homelessness," to read as follows:

> H-160.903 Eradicating Homelessness
> Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.

Policy H-160.903 originated as Resolution 401-A-15, which also was introduced by the MSS. As proposed, it asked that our AMA (1) support improving the health outcomes and decreasing health care costs of treating the chronically homeless through Housing First approaches; and (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness. The Housing First language was removed by the reference committee due to concerns regarding the "program's effectiveness among a subset of the homeless who are dually-diagnosed with mental health or substance abuse issues." The intent of the reference committee was to extend support to many approaches to combat homelessness, including but not limited to Housing First. The House of Delegates concurred with this approach.

CURRENT AMA POLICY

As noted above, existing Policy H-160.903 supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services. Additionally, Policy H-160.978 describes the components that should be included in public policy initiatives addressing the homeless who have mental health problems. These include access to care, clinical concerns, program development, and educational, housing, and research needs.

BACKGROUND

Based on the 2017 Annual Homeless Assessment Report to Congress, more than 553,000 people experience homelessness (defined as a person who lacks a fixed, regular, and adequate nighttime residence) in the United States on a single night.[1] Most (65 percent) were staying in emergency shelters or transitional housing programs, with the remaining (35 percent) staying in unsheltered locations.[1] Substance use disorders (SUD) and mental health problems are much more prevalent among people who are homeless than in the general population. According to the Office of National Drug Control Policy, approximately 30 percent of people experiencing chronic homelessness have a serious mental illness, and around two-thirds have a primary substance use disorder or other chronic health condition. Lack of stable housing leaves them vulnerable to substance use and/or relapse, exacerbation of mental health problems, and a return to homelessness.[2] Resolution 208-A-17 is specific to chronically-homeless individuals, which refers to those who are either (1) an unaccompanied homeless individual with a disabling condition who has

been continuously homeless for a year or more; or (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years.[3]

DISCUSSION

There are two common approaches to addressing homelessness in the United States, the linear approach and Housing First. The linear approach assumes that individuals who are homeless need to graduate from a sequence of programs designed to address underlying conditions before they will become "housing ready."[4] This approach also emphasizes abstinence from substance use as an explicit goal. Housing First uses a harm reduction approach by connecting individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements.[5] Case management services are offered to residents, but it is a personal choice to address SUDs or mental health problems.[6]

Federal Strategic Plan to End Homelessness

The first comprehensive federal strategic plan to prevent and end homelessness, "Opening Doors," was presented to Congress in June 2010.[3] The strategic plan was updated in 2012 and 2015 and it is anticipated that it will be updated again in 2018. Since the adoption of the federal strategic plan, the federal government has emphasized Housing First, not only as a model plan, but as a community-wide approach and guiding principle.[3] Related goals include ensuring widespread adoption of a Housing First approach, thereby lowering barriers to housing entry.[3]

Approaches to End Homelessness: The Evidence

Evidence exists to support the effectiveness of the Housing First and linear models; each model exhibits different strengths and weaknesses.[7] Housing First interventions are effective in improving housing stability and quality of life among individuals who are homeless.[6] Studies have shown that Housing First programs significantly increase the time that people are stably housed.[8-11] However, evidence is mixed on the effectiveness of Housing First in improving outcomes related to SUDs suggesting that individuals experiencing SUDs may need additional support and services to reduce substance use.[8,12]

The linear model is more effective in achieving abstinence than non-abstinence dependent housing.[13] Studied for many years as part of the linear approach to homelessness, SUD treatment programs have demonstrated moderate effectiveness, but significant problems exist with retention.[6] Even when individuals in linear service models achieve abstinence, they are vulnerable to reoccurrence of homelessness if they are not able to find permanent housing and to relapse of their SUD.[7]

CONCLUSION

There are two common approaches to addressing homelessness in the United States. The federal government has adopted the Housing First approach as a part of its national strategic plan on addressing homelessness. Evidence supports the effectiveness of Housing First in improving housing stability and quality of life in individuals who are homeless. The linear approach is more effective in achieving abstinence from substance use among those who were homeless, but such individuals remain vulnerable to reoccurrence of homelessness and relapse in their SUD. Different individuals may benefit from one approach or the other. Current AMA policy is rooted in the support of clinically proven, high quality, and cost effective approaches to reducing homelessness. Adaptive strategies based on regional variations, community characteristics, and state and local resources are necessary to address this societal problem on a long-term basis.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 208-A-17 and the remainder of the report be filed:

That Policy H-160.903, "Eradicating Homelessness," be amended to reads as follows:

H-160.903 Eradicating Homelessness
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis; and(42) supports the appropriate organizations in recognizes the need for an effective, evidence-based developing an effective national plan to eradicate homelessness.

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12. ADVOCACY FOR SEAMLESS INTERFACE BETWEEN PHYSICIAN ELECTRONIC HEALTH RECORDS (EHRS), PHARMACIES AND PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPS) (RESOLUTION 212-A-17)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

INTRODUCTION

At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 212-A-17, "Advocacy For Seamless Interface Between Physician Electronic Health Records, Pharmacies And Prescription Drug Monitoring Programs To Be Created And Financed By The Commercial EHR and

Dispensing Program Providers," which was sponsored by the American College of Legal Medicine, and which directed the AMA to:

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

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

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

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

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

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

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

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

This report summarizes the work the AMA has done in support of ensuring accurate, reliable Prescription Drug Monitoring Programs (PDMPs) that support physicians and their patients. It also addresses many of the complexities raised in the original resolution, including PDMP evolution, integration with electronic health records (EHRs) and electronic prescribing of controlled substances (EPCS). The report also provides relevant AMA policy and presents policy recommendations.

DISCUSSION

Integrating electronic systems that support efforts to end the opioid epidemic continues to be a major goal of AMA advocacy. To effectively support physician efforts to end the epidemic of opioid overdose deaths, electronic systems need to be interoperable and integrated into normal medical practice workflows. There has been progress, but effective integration remains extremely rare.

Too often, information exchanged with EHRs is not well incorporated into the physician's workflow. Important information, including PDMP data, often requires multiple "clicks," opening multiple windows, and requiring separate logins even before the physician finds what he or she is looking for—and that situation must be repeated for

each patient and every prescription for a controlled substance. Effective PDMP and EHR integration means that the workflow must achieve "functional interoperability," or the ability for systems to exchange, incorporate and display data in a meaningful and contextual manner.

Many consider the ideal practice to be a "one-click" solution with PDMP data and EPCS integrated into physicians' EHR systems. However, EHR vendors currently are pulled in too many directions to focus on this need. Federal regulations require vendors to spend considerable time developing EHRs that meet administrative requirements. To achieve the ideal, more must be done to reduce the regulatory pressure on health IT development, allowing vendors flexibility to respond to physician and patient needs, rather than spending the bulk of their time complying with administrative demands.

One area where there has been significant progress is interoperability between the various state PDMPs. According to the National Association of Boards of Pharmacy, 44 states now can securely share PDMP information across state lines.[1] PDMP use among physicians and other health care professionals has significantly increased in recent years, with more than 136 million queries taking place in 2016,[2] the most recent year for which data are available.

Progress has been considerably slower in achieving EPCS uptake,[3] however, largely due to outdated regulations from the Drug Enforcement Administration (DEA). The combination of personal identification numbers (PINs), passwords, and biometrics required to meet DEA standards for "two-factor authentication" increase EPCS security but add to workflow disruptions and increase costs. DEA EPCS requirements include onerous limits on use of biometric devices, which must comply with federal standards that set an unnecessarily high bar and prevent use of user-friendly consumer electronics already found in physicians' offices for two-factor authentication. The biometric fingerprint scanners found on these consumer devices, i.e., smart phones, tablets, and laptop computers, are used for secure access to other sensitive information, like banking and medical records, but typically do not comport with rigid rules for EPCS.

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

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

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

The AMA also continues its efforts in support of making PDMPs better clinical tools. The use of PDMPs continues to increase in states with and without mandates—tied mainly to quality of the PDMP as a decision-support tool. Important policies that have led to improved PDMP workflow and data reliability include delegate access, data input

by pharmacists within 24 hours, and sharing of PDMP information by 44 states. PDMP usability continues to improve, but access in rural and other areas may be affected by lack of access to broadband and other technologies. Consistent, long-term funding of state PDMPs is also a concern—most states depend on federal grants for ongoing maintenance and improvements. The AMA also continues to try and identify best practices in designing PDMPs to identify risk including: distinguishing between uncoordinated care, misuse, and "doctor shopping," identifying opportunities for referrals to specialized care; providing reports to prescribers to better inform prescribing decisions; and conducting public health surveillance.[4]

One best practice is PDMP and EHR integration, but that remains largely elusive. It is not clear, for example, how many PDMPs are integrated into EHRs, which makes identification of best practices challenging given the variety of EHR systems in the market. Each state PDMP may require a slightly different interface to connect to an EHR. With over 600 different EHRs on the market, the number of custom EHR/PDMP interfaces can reach into the thousands. Custom software development is time-consuming and expensive—with costs being passed down onto the physician. Without PDMP and EHR integration, physicians must use multiple usernames and passwords to shuttle between different systems, often having to re-enter login information if one system times out while they are using the other one. This results in increased time to enter information, decreased satisfaction with the technology, and potentially less use of the systems.

In addition, EHRs are generally not interoperable between different organizations, making coordination between primary care physicians, pain medicine physicians, addiction medicine physicians and other providers much more difficult. When PDMP and EHR integration does exist (e.g., Oregon's EDIE), the patient, public health and cost utilization benefits are extremely positive.[5] This integration requires time and broad, institutional support. For example, the state of Washington's integration project with the state Health Information Exchange (HIE) began in 2012. As of August 2017, more than 90 percent of emergency departments include PDMP data in the EHR using data through the HIE.[6] The state's major health systems still are working to accomplish this integration.

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

The AMA also has been engaged in the SMART project to help EHR systems work better for physicians and patients. A key component of this effort is the development of a flexible information infrastructure that allows for free, open development of plug and play applications (apps) to increase interoperability among health care technologies, including EHRs, in a more cost-effective way. The infrastructure development specific to PDMPs is part of both ongoing research as well as work by states working to achieve more comprehensive data integration.[7] In addition, the Office of the National Coordinator for Health Information Technology has compiled multiple sources and pilot examples for PDMP and EHR integration.[8] The pilot examples, not surprisingly, found that PDMPs were most helpful when they were integrated into physicians' workflow as well as EHRs.

AMA POLICY

The AMA House of Delegates has provided strong guidance to the AMA that reflects the issues raised by the original resolution that is the subject of this report. Relevant policies include: H-120.957, "Prescription of Schedule II Medications by Fax and Electronic Data Transmission," which "encourages the Drug Enforcement Administration to support two factor authentication that is easier to implement than the current DEA and EPCS security requirements; and because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, does not support the use of "hard copy" facsimile transmissions as the original written

prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations." In addition, H-95.928, "Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing," provides that the AMA support multiple facets of PDMP development, including interoperability, assisting physicians and pharmacists in identifying "when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame." In addition, D-478.972, "EHR Interoperability," calls for the AMA to continue efforts in support of EHR interoperability standards, reducing excessive costs and generally reducing barriers to EHR adoption. Finally, Policy D-478.994, "Health Information Technology," broadly notes AMA support for "legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology," which reasonably would include PDMP, EPCS and EHR uptake.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying how PDMPs can distinguish team-based care from uncoordinated care, misuse, or "doctor shopping," as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care.

2. That our AMA urge EHR vendors to increase transparency of custom connections between their products and PDMP software.

3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring.

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13. MERGERS OF SECULAR AND RELIGIOUSLY AFFILIATED HEALTH CARE INSTITUTIONS AND THEIR IMPACT ON PATIENT CARE AND ACCESS TO SERVICES

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy TBD

Policy D-140.956, "Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient Centered, Safe Care Services," asks that the American Medical Association (AMA):

> conduct a study of access to care in secular hospitals and religiously affiliated hospitals to include any impact on access to services of consolidation in secular hospital systems and religiously affiliated hospital systems.

AMA lacks the necessary research infrastructure to carry out an extensive empirical study regarding the impact of such mergers on patients' access to care. This report reviews the best evidence currently available in this area from governmental agencies, academic institutions, and scholarly and popular publications. Council on Ethical and Judicial Affairs Report 2-A-18, "Mergers of Secular and Religiously Affiliated Health Care Institutions," provides ethics guidance for physicians in this context.

BACKGROUND

The changing landscape of the American healthcare sector and evolving market forces have motivated health care institutions to consider mergers, acquisitions, partnerships, and other types of transactional relationships for the purpose of consolidation [1]. The economic recession from 2007 to 2009 and the passage of the 2010 Affordable Care Act (ACA) may have played a substantial role in driving mergers in recent years; 112 mergers were reported in 2015, compared to 105 in 2012 and 66 in 2010 [1,3]. With the ACA encouraging the creation of Accountable Care Organizations for coordinated care and new value-based payment models, health care institutions were encouraged to merge and create economies of scale to reduce expenses and share profits across larger patient volumes, standardize and streamline protocols to improve operational efficiency, and expand their scope of services and care networks to facilitate patient access [3–5].

RELIGIOUSLY AFFILIATED HEALTHCARE IN THE UNITED STATES

Secular and religiously affiliated institutions alike feel pressures to merge [6], in particular, small, independent, rural, and/or financially struggling hospitals [7]. Rural populations often face wide health disparities and lack of access to care, and over 2,000 rural hospitals struggle operationally and financially with low patient volume, provider shortages, and poor facilities and resources [8]. Since 2010, more than 60 rural hospitals have closed in 20 states, and several hundred more may be vulnerable to closure, especially in southern states [9]. Because of these issues, rural hospitals may be particularly susceptible to external and economic forces that lead them into merger transactions.

Religiously affiliated or faith-based health care institutions can include hospitals, clinics, and other centers of care partnered with, established by, owned by, and/or managed by a wide array of religious entities in the U.S., such as Catholic, Protestant (e.g., Methodist, Presbyterian, Baptist, Evangelical, Adventist), Mormon, and Jewish organizations. Catholic institutions are the most numerous, comprising over 600 hospitals and over 1,600 clinics and other care facilities [10]. Collectively, they serve as the nation's largest group of nonprofit health care providers [10,11]. Catholic hospitals constitute nearly 15 percent of all acute care hospitals, treating about one-sixth of all acute care hospital patients, with 5 million admissions and 20 million emergency room visits a year [10]. Since 1997, over 140 mergers have occurred between non-Catholic and Catholic institutions [12]. From 2000 to 2016, the number of acute care hospitals with Catholic affiliations grew 22 percent, even as the overall number of acute care hospitals declined [11]. Ten of the 25 largest health systems are Catholic-affiliated [11]. An estimated 25 percent of Catholic hospitals and 15 percent of Catholic continuing care facilities are located in rural areas [10]. Out of over 1,300 Critical Access Hospitals (specially designated hospitals located in high-need rural areas), 132 are Catholic-affiliated [10,13]; as of 2016, 46 Catholic hospitals were the sole health providers for their communities [11].

Protestant and Jewish institutions also form a prominent part of the religiously affiliated healthcare sector. In the U.S., around 50 hospitals and health systems are affiliated with the United Methodist Church; the Adventist Health System manages 46 facilities; and close to 20 Jewish hospitals are in operation; accurate figures are difficult to find for the numbers of Presbyterian, Baptist, Mormon, or other health care institutions [14,15,16].

THE IMPACT OF MERGERS ON PATIENT CARE

Evidence about the impact of mergers between secular and religiously affiliated institutions is limited and largely anecdotal in nature. Much of our knowledge of these issues is derived from news articles and reports from advocacy organizations such as the American Civil Liberties Union (ACLU) and MergerWatch.

Based on what evidence we have the effects on clinical services and care of mergers that involve non-Catholic religiously affiliated institutions appear to be diverse. For example, some Baptist, Adventist, and Mormon institutions are opposed to abortions in accordance with their principles [1,2]; other merged entities, such as Missouri's Barnes-Jewish Hospital, and the Protestant-affiliated Advocate Health Care in Illinois do provide abortions [17,18,19]. (An institution's faith tradition may shape nonclinical aspects of patient experience, as when Jewish hospitals observe Shabbat and Jewish holidays, display ritual objects, provide kosher meals, or designate kitchens for Orthodox patients [20]. Similarly, at least one Adventist institution declines to serve nonvegetarian food or any stimulants [21,22].)

Not surprisingly given the prominence of Catholic institutions in U.S. health care, the published material focuses heavily on mergers that involve Catholic organizations, which are governed by the *Ethical and Religious Directives for Catholic Health Services* (ERDs) issued by the U.S. Conference of Catholic Bishops [23]. The ERDs address many aspects of institutional life in Catholic and Catholic-affiliated facilities, providing directives not only regarding the services available to patients, but also directives to guide partnerships between Catholic and non-Catholic health care institutions [23]. Other faith-based health care organizations do not have a comparable body of detailed formal directives, though the websites of faith-based health systems or individual facilities generally state the institution's core values.

Religious Directives for Catholic Health Services

The Catholic Health Association of the United States (CHA) identifies its member institutions as ministries of the Catholic Church [24]. In line with the religious values of the Church and the guidance of the ERDs, Catholic institutions often restrict the provision of certain health services, particularly in reproductive care [11,23]. The ERDs state that "abortion…is never permitted," although "operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable" [23]. Additionally, Catholic institutions "may not promote or condone contraceptive practices," and "direct sterilization of either men or women, whether permanent or temporary, is not permitted" [23].

Reproductive Health Services. Women have been denied a wide range of reproductive services at Catholic hospitals, even when there may be substantial risk to the woman's health or life of the patient [25–28]. Women with nonviable pregnancies have reportedly been turned away from Catholic hospitals until severe hemorrhaging or infection occurs [29]. In other cases, patients who request tubal ligations to be performed at the same time as a C-section are refused this service, even if future pregnancies are risky [29]. Obstetrician-gynecologists have also reported feeling unduly constrained by Catholic hospital administrators when exercising their clinical judgment in managing miscarriage, nonviable pregnancies, and serious maternal complications [30–32]; in one sample, 52 percent of obstetricians-gynecologists in Catholic institutions reported experiencing conflict with their hospital's religious policies [32].

In 2010 in rural Arizona, the secular Sierra Vista Regional Health Center became affiliated with the Catholic-based Carondelet Health Network and adopted the ERDs to guide its clinical services [25]. In one incident at Sierra Vista, a physician is reported to have recommended termination of pregnancy to a woman who had miscarried one of her twins and faced a low chance of the other twin's survival and high risk of hemorrhage and infection. A hospital administrator denied the procedure; however, and the patient was instead driven by ambulance to a hospital 80 miles away for treatment. After the incident, Sierra Vista broke their relationship with Carondelet after one year of a two-year trial period and chose to affiliate with a secular network instead.

Patients have also reported being unaware that the services they want will not be provided until they have already arrived at a Catholic hospital or begun treatment, and religious facilities can be unwilling to refer patients elsewhere [26,29].

This is not to say that Catholic facilities always adhere strictly or uniformly to the ERDs. For example, under the ERDs, men could also be refused many reproductive services, including contraception, sterilization, and participation in decisions on prenatal diagnosis and artificial insemination [23]; however, at least one Catholic health system, Ascension Health, performs vasectomies for men but not tubal ligations for women [33]. In 2010, Sister Margaret McBride, an administrator at a Catholic Healthcare West hospital in Arizona, authorized the termination of a pregnancy due to the high risk of mortality for both mother and child [33]. Although both the CHA and the hospital supported McBride's decision, the local diocesan bishop later excommunicated McBride and stripped the hospital of its Catholic affiliation, causing controversy in the Catholic health community [34].

Services for Transgender Patients. The CHA does not specifically deny services on the basis of sexual orientation. In January 2018, Sister Carol Keehan, president and CEO of the CHA, stated that "any services [that Catholic institutions] offer are available to everybody," elaborating that "transgender patients have heart attacks … and gallbladder surgery" and that "[Catholic hospitals] have delivered many a lesbian couple's baby and many a gay couple's baby" [35]. The Human Rights Campaign's Healthcare Equality Index evaluates nearly 600 American hospitals on the basis of their care, services, and policies relating to LGBTQ individuals and has previously rated several Bon Secours hospitals, which are members of the CHA, with moderate to high scores [36].

However, Catholic institutions have refused to perform gender-affirming surgery in the past; in one example, Franciscan Health in Indiana sued the Obama administration over a gender identity nondiscrimination rule mandated by the ACA [37]. The National Catholic Bioethics Center believes that "no Catholic health care organization should require its personnel to carry out, promote, refer for, or otherwise cooperate formally in procedures involved in gender transitioning, especially surgical or hormonal intervention" [38]. In 2017, the CHA's senior director of ethics and theology stated, "For most medical providers the issue is settled in terms of seeing gender dysphoria as something that can be treated legitimately…[but] Catholic ethicists still have many questions about its moral permissibility" [39]. There have been media reports of instances in which transgender patients have been denied hysterectomies under the ERD restriction on sterilization [40,41] and mastectomies [42–44].

Physician-Assisted Suicide. In U.S. jurisdictions that have legalized physician-assisted suicide—as of March 2018, California, Colorado, the District of Columbia, Hawaii, Montana, Oregon, Vermont, and Washington—access to legally permitted "aid in dying" is unlikely to be available from religiously affiliated institutions and clearly will not be from Catholic-affiliated institutions. In guidance on care for patients who are seriously ill or dying, the ERDs unequivocally prohibit intentionally hastening death, stating "Suicide and euthanasia are never morally acceptable options" [23]. The ERDs provide that "Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way" [23].

The possible impact of these or similar restrictions is difficult to estimate, but reports indicate that the ERDs have had an effect in jurisdictions where physician-assisted suicide is legal. For example, in Washington state in 2010, the Catholic-affiliated PeaceHealth merged with the Clark County public hospital, which then stopped referring patients for PAS-related counseling [45]. In 2013, physicians at Harrison Medical Center in Bremerton, Washington, were restricted from prescribing medications for assisted suicide after Harrison affiliated with the Catholic-based Franciscan Health System [46]. As of 2012, some 30 percent of hospital beds in Washington were owned by Catholic institutions [47].

Effects on Health Plans

There is also evidence to suggest that mergers among secular and religiously affiliated health care institutions can affect the terms of health insurance plans. In 2017 in northwestern Indiana, for example, a proposed merger between a Catholic-affiliated Franciscan system and Methodist Hospitals would have left only one non-Catholic hospital in the county [37]. This hospital would not be included in the network of the only insurer offering plans for the region on the ACA exchange, in effect making Franciscan Health and Catholic hospitals exclusive providers for this plan. This may have forced patients on this plan to travel out of their network to receive services not provided by in-network facilities [37]. Some large Catholic health systems, such as Catholic Health Initiatives and Ascension Health, have also expressed interest in offering their own health insurance plans as they have expanded their merged

systems [37]. Catholic institutions attaining exclusive provider status with insurance plans, especially those offered by employers or on subsidized ACA exchanges, could create serious concerns for patient access to care.

CONCLUSION

Although there has been limited scholarly research regarding the clinical impact specifically of mergers among secular and religiously affiliated health care institutions, this literature suggests that patients may have more difficulty gaining access to some services as a result of such mergers. A growing body of anecdotal evidence in the form of media reports describing cases in which these mergers appear to have affected care for individual patients argues to a similar conclusion, as do efforts to monitor the impact of mergers among advocacy organizations.

RECOMMENDATION

Your Board of Trustees concludes that the foregoing fulfills Directive D-140.956, "Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient Centered, Safe Care Services," and recommends that the directive be rescinded and the remainder of this report be filed.

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14. INTEGRATION OF DRUG PRICE INFORMATION INTO ELECTRONIC MEDICAL RECORDS/ BARRIERS TO PRICE TRANSPARENCY/BIDIRECTIONAL COMMUNICATION FOR EHR SOFTWARE AND PHARMACIES/HEALTH PLAN, PHARMACY, ELECTRONIC HEALTH RECORDS INTEGRATION (RESOLUTIONS 219-A-17, 213-I-17, 203-I-17 AND 205-I-17)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED**
IN LIEU OF RESOLUTIONS 209-A-17, 213-I-17, 203-I-17 and 205-I-17
REMAINDER OF REPORT FILED
See Policies H-110.987, H-110.988, H-110.991, H-110.997, D-155.987 and D-478.963

INTRODUCTION

At the 2017 Annual Meeting Resolution 219-A-17, "Integration of Drug Price Information into Electronic Medical Records," was referred by the House of Delegates (HOD). Resolution 219-A-17 was introduced by the Medical Student Section and asks the American Medical Association (AMA) to support the incorporation of estimated patient out-of-pocket drug costs into electronic medical records (EMR) and collaborate with invested stakeholders, such as physician groups, EMR vendors, hospitals, insurers, and governing bodies to integrate estimated out-of-pocket drug costs into electronic medical records in order to reduce patient cost burden.

At the 2017 Interim Meeting, Resolution 213-I-17, "Barriers to Price Transparency," was introduced by the American Academy of Dermatology, American Society of Dermatologic Surgery Association, American College of Mohs Surgery, American Society of Dermatopathology, and the Society for Investigative Dermatology. The third resolve of Resolution 213-I-17 was referred by the HOD and asks the AMA to support access to real-time prescription drug pricing and cost transparency at the point of prescribing.

Also at the 2017 Interim Meeting, Resolutions 203-I-17, "Bidirectional Communication for EHR Software and Pharmacies," and 205-I-17, "Health Plan, Pharmacy, Electronic Health Records Integration," were referred together.

Resolution 203-I-17 was introduced by the Medical Society of Virginia, the Kentucky Medical Association, the North Carolina Medical Society, the American Urological Association, and the American Association of Clinical Urologists. Resolution 203-I-17 asks the AMA to engage the American Pharmacy Association, and any other relevant stakeholders, to encourage both electronic health record (EHR) and pharmacy software vendors to have bidirectional communication for an accurate and current medication list in the patient's EHR.

Resolution 205-I-17 was introduced by the Medical Society of Virginia, the Kentucky Medical Association, the American Urological Association, and the American Association of Clinical Urologists. Resolution 205-I-17 asks the AMA to advocate that health plans, pharmacies, and EHR vendors integrate their technology programs so that physicians have current and real time access to covered medications for patients within a specific health plan. Resolution 205-I-17 also requests that the AMA advocate that health plans make patient cost information readily available via this technology so that physicians and their patients may work together to choose the most cost-effective medically appropriate medication for patient care.

All resolutions were referred for report back at the 2018 Annual Meeting. As the referred resolves in each resolution deal with components of a common issue, this report will address the topic as a whole, and present recommendations accordingly.

BACKGROUND

Prescription drug costs in the United States are significant and rising. Some research shows the patient out-of-pocket prescription costs are decreasing, although overall drug spending has increased[1] and approximately 25 percent of Americans who regularly take prescription medications saw a price increase from 2016 to 2017.[2] There is significant correlation between increased patient prescription cost sharing and decreased medication adherence,[2, 3] suggesting an adverse effect on patient outcomes.

Many physicians report not having access to drug price information at the point of prescribing,[4] often preventing them from sharing the information with the patient and gaining awareness of whether a patient can afford the medication. Studies show increased physician awareness of drug prices changes prescribing behavior and reduces overall medication expenditures.[5] The AMA recognizes that physicians can enhance patient-centered care by balancing costs and the potential for patient adherence to prescriptions in their decision-making related to maximizing health outcomes and quality of care for patients.

Improving drug price transparency would increase patient and physician awareness of the overall costs associated with different prescription drug treatment options and ultimately facilitate better-informed, shared treatment decisions that could help reduce prescription drug spending. Integrating drug price information into EHRs would support point-of-prescription cost transparency that could increase a physician's ability to provide price information to patients. Although various barriers have historically inhibited the provision of drug price information at the point of prescribing, key stakeholders have taken significant steps in recent months towards overcoming these barriers and implementing solutions.

AMA POLICY

The AMA is committed to working with federal and state agencies, policymakers and other relevant stakeholders to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs (Policy H-110.988, "Controlling the Skyrocketing Costs of Generic Prescription Drugs"). The AMA supports increasing physician awareness about the cost of drugs prescribed for their patients (Policy H-110.996, "Cost of Prescription Drugs"), and encourages physicians to become familiar with the cost of drugs in their communities and to consider prescribing the least expensive drug treatment available (Policy H-110.997, "Cost of Prescription Drugs"). The AMA emphasizes the importance of value-based decision-making in health care, and the need for physicians to have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. AMA policy also asserts that physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making (Policy H-450.938, "Value-Based Decision-Making in the Health Care System"). The AMA also encourages physicians to communicate information about the cost of their professional services, including prescriptions, to individual patients, and encourages EHR vendors to include features that assist in facilitating price transparency for physicians and patients (Policy D-155.987, "Price Transparency").

The AMA is dedicated to actively engaging with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency, and helping ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide

(Policy D-155.987, "Price Transparency"). It is AMA policy that in order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, and pharmacies should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to their provision. There should be a similar requirement that insurers make available in standard format information on the amount of payment provided toward each type of service identified as a covered benefit (Policy H-373.998, "Patient Information and Choice"). The AMA encourages implementation of practices that increase price transparency among other stakeholders, including pharmaceutical companies, pharmacy benefit managers and health insurance companies (Policy H-110.987, "Pharmaceutical Costs"). Additionally, the AMA advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay, and is committed to pursuing legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication (Policy H-110.991, "Price of Medicine"). The AMA is also committed to working with EHR vendors to enhance transparency and establish processes to achieve data portability (Policy D-478.995, "National Health Information Technology").

DISCUSSION

Lack of transparency in prescription drug pricing is a major contributor to the increasingly high prices of drugs.[4, 6, 7] Prescription price transparency is an important factor in lowering patients' out-of-pocket costs and preventing prescription abandonment, a common cause of medication non-adherence, which negatively impacts patient safety and costs an estimated $300 billion each year in avoidable medical spending.[8]

Efforts can be made at multiple levels to improve the visibility of drug prices. For example, transparency of drug prices can be increased at the point-of-purchase level, when patients are interacting with the pharmacist to fill or refill a prescription. Historically, gag clauses in pharmacy benefit manager (PBM) contracts have prevented pharmacists in many states from informing consumers that the drug they want to purchase could be purchased at a lower cost if the consumer paid out of pocket rather than through their insurance plan. Some states are considering legislation, and several have passed laws, that ban restrictive gag clauses in PBM contracts with pharmacies. Eliminating these restrictions allows pharmacists the freedom to inform patients about the least expensive way to obtain the medication they have been prescribed.

At the point of prescribing, when a physician is discussing treatment options during a clinical visit, the price of a drug could be a deciding factor in whether the treatment is pursued; however, prescribers are largely unaware of the prices associated with the medications they prescribe and have difficulty estimating costs with accuracy.[9, 10] Some EHR platforms display limited high-level drug price information, such as co-pay tiers and dollar sign rating scales, giving a general estimate or range for the patient's portion of a drug's cost. These data are based on static "flat" files provided by PBMs to EHR vendors using the National Council for Prescription Drug Programs (NCPDP) Formulary and Benefit standard.[11] This information is not always up to date or accurate, however, since payers or PBMs may change a drug formulary or reclassify a particular prescription without the physician's or patient's knowledge and/or without providing updated formulary data to EHR vendors. This can further hinder the provision of accurate drug cost information to patients and physicians, presenting another opportunity for improved transparency.

Universally integrating real-time drug price information, along with improving the reliability and granularity of the currently available formulary and benefit information, into EHR systems would provide physicians with a more accurate estimate of a patient's potential cost for a given medication. Since 2014, NCPDP has been working on a real-time pharmacy benefit check solution through the work of their Real-Time Benefit Check Analysis Task Group (more recently named the Real-Time Prescription Benefit Standard Task Group). This group's goal is to develop an electronic standard for communicating real-time drug pricing information to physicians at the point-of-prescribing in EHR systems. Data points would include formulary status, tier structure, restrictions such as prior authorization and step therapy requirements, patient co-pays, and therapeutic alternatives that may be more affordable for the patient.[11]

While NCPDP continues developing a real-time pharmacy benefit standard, vendors and PBMs are piloting this technology in proprietary formats. In 2017, Surescripts, six major EHR vendors including Allscripts, Cerner, GE, Epic, Practice Fusion and Aprima, along with CVS Health, partnered to deliver a system that provides prescribers with the cost of medications, specifically based on the patient's insurance coverage, as well as other therapeutic treatment options to ensure the patient and physician can decide together the most appropriate and affordable course of treatment. This collaborative service is planned to be available in 2018. This development is an important step

toward a sustainable solution; however, for it to be viable and universally beneficial the data must be available across all EHR vendors for all patients with all payer information.

There is mixed evidence on whether providing prescribers with cost information at the point of prescribing results in significant changes to prescribing behavior, overall costs, or improvements to medication adherence. One study showed evidence that providing physicians with information about drug prices increased generic prescribing and decreased orders for diagnostic tests, and that "gatekeeper" physicians reduced use of hospital and specialist services when regularly presented with prescription cost information.[12] Another study demonstrated that having access to the charges associated with patient care changed practice patterns and decreased patient charges, thereby improving cost containment efforts.[13] An analysis of prescriptions and use of a point-of-care electronic drug reference database for over 125,000 U.S. physicians found that physicians using the database prescribed a significantly more diverse set of products, were faster to begin prescribing new generic drugs, and also had a greater propensity to prescribe generics. The researchers attributed this finding to the database users' access to non-clinical information such as drug price and insurance formulary data.[14]

However, a separate study reviewed the total and out-of-pocket cost changes for diabetes patients whose physicians had access to drug formulary and price information and found that while the total drug costs increased at a lower rate, having access to the cost information did not reduce the patient out-of-pocket cost or increase medication adherence rates.[15] Similarly, a study published in *JAMA Internal Medicine* demonstrated that displaying Medicare allowable fees for inpatient laboratory tests did not lead to a significant change in overall clinician ordering behavior or associated fees.[16] Overall, researchers have found that while access to drug price and coverage data may influence prescriber decisions, providing price information alone is not enough and that more comprehensive approaches are in order. Some conclude that transparency in price is most beneficial when combined with education and an audit/feedback mechanism for prescribers.[9] Others assert that prices for individual components of care provide an incomplete picture of the patient's out-of-pocket responsibility, and that seeing prices for episodes or bundles of care could allow patients and physicians to assess value and treatment together.[17]

The issue of drug price transparency is one of great importance to the AMA and our current advocacy efforts reflect our commitment to addressing the issue at the state and federal levels. The Chair of the AMA Board of Trustees presented testimony at the December 2017 Energy and Commerce hearing on drug pricing to ensure AMA's position and the voice of physicians continues to be represented. Another example of this work is the AMA's interactive grassroots website TruthinRx.org, which urges improved drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers, and health plans and offers patients the opportunity to share their stories of how rising prices affect their physical and financial health. At the state level, the AMA's model legislation on drug pricing transparency seeks to provide patients with relevant, accurate information about the manufacturing, production, advertising, and other associated costs relating to prescription medications and institute consumer protections for sudden drug price fluctuations.

The AMA's advocacy efforts on prior authorization reform address the need for accurate formulary data in EHRs. In January 2017 the AMA, in collaboration with 16 other organizations representing physicians, hospitals, pharmacists, medical groups, and patients, released a set of 21 Prior Authorization and Utilization Management Reform Principles. Of note is Principle 9, which states "Utilization review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in [EHR] systems for purposes that include e-prescribing." The AMA has used these principles to spur conversations with health plans about "right-sizing" prior authorization programs. One outcome of these discussions was the January 2018 release of the Consensus Statement on Improving the Prior Authorization Process by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. The consensus document reflects an agreement between national associations representing both providers and health plans on the need to reform prior authorization programs in multiple ways, including advancing automation to improve transparency and efficiency. Specifically, the consensus statement "[e]ncourage[s] the communication of up-to-date prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers, relative costs, and covered alternatives . . . to EHR, pharmacy system, and other vendors to promote the accessibility of this information to health care providers at the point-of-care via integration into ordering and dispensing technology interfaces." This reflects the widespread agreement among providers and health plans about the need for accurate drug pricing information in EHRs.

The AMA is actively involved in standards development work and direct discussions with vendors to improve formulary data technology. The AMA participates in meetings of the NCPDP's Real-Time Prescription Benefit Standard Task Group and the Formulary and Benefit Task Group to ensure the physician voice is represented in the development of standards and solutions. The AMA dedicates significant resources to improving usability, interoperability and value in EHRs. Incorporating prescription drug price information into EHRs will enhance the AMA's efforts to increase the value and utility of these systems.

The AMA recognizes the need for more knowledge about the current availability and accessibility of the features described in these resolutions, including EHR, pharmacy and payer functionalities that enable integration of price, insurance coverage, formulary tier and drug utilization management policies, and patient cost information. As a more robust knowledge base is obtained as a result of private sector initiatives such as that of Surescripts and others, the AMA will encourage collaboration with other vendors and other key stakeholders to develop a plan for improving the availability and accessibility of this important information to all physicians. This effort, along with our existing commitment to pursuing legislation to increase price transparency at the payer and pharmacy levels, would further the AMA's strategic goals to reduce health care costs and improve health outcomes.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 219-A-17, 203-I-17, 205-I-17, and 213-I-17, and that the remainder of the report be filed.

1.   That our American Medical Association reaffirm Policies H-110.988, "Controlling the Skyrocketing Costs of Generic Prescription Drugs," H-110.997, "Cost of Prescription Drugs," D-155.987, "Price Transparency," H-110.987, "Pharmaceutical Costs," and H-110.991, "Price of Medicine;"

2.   That our AMA collaborate with other interested stakeholders to explore (a) current availability and accessibility of EHR, pharmacy and payer functionalities that enable integration of price, insurance coverage, formulary tier and drug utilization management policies, and patient cost information at the point of care, (b) at what levels barriers exist to this functionality or access, and (c) what is currently being done to address these barriers;

3.   That our AMA collaborate with other interested stakeholders to develop and implement a strategic plan for improving the availability and accessibility of real-time prescription cost information at the point of care.

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17. Sinaiko, A.D. and A.T. Chien, *Achieving the promise of price transparency.* JAMA Internal Medicine, 2017. 177(7): p. 946-947.

15. ADVANCED PRACTICE REGISTERED NURSE COMPACT

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED**
REMAINDER OF REPORT FILED
See Policy H-35.988

This report is submitted for the information of the House of Delegates. So as to not expose sensitive advocacy strategies and potential future resources, a fuller accounting of the Scope of Practice Summit ("Summit") described herein will take place through AMA meetings dedicated to advocacy and scope of practice, as well as the confines of the Scope of Practice Partnership (SOPP).

Policy adopted at the 2017 Interim Meeting called on the American Medical Association to convene an in-person meeting of relevant physician stakeholders to initiate creation of a consistent national strategy to effectively oppose efforts to grant independent practice to non-physician practitioners. (Policy H-35.988, "Independent Practice of Medicine by Advanced Practice Registered Nurses").

The resultant Summit was held March 20, 2018 at AMA headquarters in Chicago. The SOPP provided funding to support the Summit. In addition, the SOPP awarded 14 scholarships to state medical associations that otherwise would have been unable to attend.

Attendance included 81 physicians, executive staff, and government affairs staff from 32 state medical associations, 16 national medical specialty societies, and the American Osteopathic Association. Representatives of the AMA Board of Trustees and Council on Legislation, and AMA staff from Advocacy, Office of General Counsel, Physician Engagement, and Enterprise Communications and Marketing also attended the Summit.

William E. Kobler, MD, member, AMA Board of Trustees and chair of the SOPP, served as chair of the Summit. Dr. Kobler led a planning committee composed of executive staff of the American Academy of Family Physicians, American Academy of Ophthalmology, American Congress of Obstetricians and Gynecologists, American Psychiatric Association, American Society of Anesthesiologists, California Medical Association, Medical Association of Georgia, New Mexico Medical Society, Ohio State Medical Association, and Medical Society of Virginia. This planning committee was instrumental in shaping the Summit agenda, and the Board of Trustees thanks them for their time and effort.

With the assistance of a strategic research firm prior to the Summit, the AMA Advocacy Resource Center conducted a survey of all associations invited to the Summit. Feedback from 60 respondents about scope of practice advocacy and trends was synthesized in a presentation to kick-off the Summit. This valuable insight was also utilized throughout the Summit's strategic planning session.

Meeting attendees heard presentations about the considerable scope of practice advocacy resources of the AMA Advocacy Resource Center and SOPP, including the Health Workforce Mapper, Geographic Mapping Initiative, Scope of Practice Data Series Modules, model bills, state law charts, issue briefs, talking points, public opinion research, and comprehensive state legislative campaigns including the Physician-Led Team Campaign and Truth in Advertising Campaign, and grant funding. Attendees also heard a case study from a state medical association that heavily utilized SOPP resources and a SOPP grant to fight a nurse practitioner independence bill; and a panel of national medical specialty society representatives discussing scope priorities and trends.

The afternoon was dedicated to a strategy session, in which facilitated small and large group discussions identified strengths, opportunities, weaknesses, and threats related to scope of practice advocacy. The strategy session also

identified ways in which to amplify strengths and opportunities within organized medicine while addressing weaknesses and internal and external threats. A professional facilitator with government affairs expertise moderated the discussion.

Results of a meeting evaluation were positive. Of the responses, 98 percent reported that the conference fully or partially fulfilled their reason for attending, and 85 percent would recommend the meeting to colleagues. 95 percent of attendees were pleased with the quality of the presentation and the scope of the information presented. 88 percent of respondents left with a somewhat or much better view of the AMA; the remainder reported that their opinion of the AMA was unchanged.

The Board of Trustees recommends that Policy H-35.988(2) be rescinded, having been accomplished through the Scope of Practice Summit and this report.

RECOMMENDATION

The Board of Trustees recommends that Policy H-35.988(2), "Independent Practice of Medicine by Advanced Practice Registered Nurses," be rescinded and that the remainder of this report be filed.

16. PROTECTION OF CLINICIAN-PATIENT PRIVILEGE
(RESOLUTION 237-A-17)

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 237-A-17
REMAINDER OF REPORT FILED**
See Policy H-315.983

INTRODUCTION

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 237-A-17, "Protection of Clinician-Patient Privilege," for report back at the 2018 Annual Meeting. This resolution was introduced by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont Delegations and asked that our American Medical Association (AMA):

Advocate to the relevant national bodies for the clinician-patient privilege to be regulated according to the privacy protections in the Health Insurance Portability and Accountability
Act of 1996 (HIPAA) without regard to where care is received.

This report provides information about the privacy protections and exceptions thereto found in the Family Education Rights and Privacy Act (FERPA) in post-secondary educational settings. It also compares such protections and exceptions to those found in HIPAA. Finally, it discusses which of the two standards is more appropriate for the AMA to support.

BACKGROUND

FERPA is a federal law that applies to educational institutions—including most public and private post-secondary institutions—that receive funding from the U.S. Department of Education. It protects the privacy of information found within students' "education records," which is broadly defined to mean those records that are (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution.[1] FERPA prohibits a post-secondary institution from disclosing personally identifiable information (PII) from a student's education records absent that student's written consent, unless an exception applies.[2]

Education records can include medical records (for example, immunization records), but are separate and distinct from "treatment records." Treatment records are defined in post-secondary institutions as those made or maintained by a physician, psychiatrist, psychologist, or other recognized professional acting in his or her professional capacity

and in connection with treatment of a student at the institution.[3] By definition, these records may be disclosed only to individuals providing treatment to the student (not even to the student him or herself), unless the student provides written consent or an exception applies.[4] Once a disclosure is made to anyone other than the student's treating clinicians, the record is no longer considered a treatment record, but rather an education record subject to FERPA's general disclosure rules.[5]

As noted above, there are instances in which a school may disclose both education and treatment records even when the student does not provide written consent.[6] Examples include:

- For the legitimate educational interests of other educational institutions;
- To make financial aid determinations;
- To authorized representatives of the United States government;
- To parents of dependent students;
- To comply with a judicial order or lawfully issued subpoena;
- If the educational institution initiates legal action against a parent or student; and
- If a parent or student initiates legal action against the educational institution.

HIPAA, the federal privacy law applicable to most medical records, prohibits the use and disclosure of protected health information (PHI) by covered entities (e.g., clinicians and health care facilities) absent written patient authorization, unless an exception applies.[7] Common exceptions include:

- Treatment (including disclosure of information to other health care providers);
- Payment;
- Health care operations (including for litigation purposes where the covered entity is a party to the proceedings);
- For public health purposes;
- To authorized representatives of the United States government;
- To parents of minors; and
- To comply with a judicial order or lawfully issued subpoena.

DISCUSSION

Both HIPAA and FERPA permit disclosure of medical information without a patient's written authorization for certain purposes. Specifically, with respect to disclosures for legal proceedings, HIPAA requires that a covered entity disclose only the minimum amount of information necessary to accomplish the intended purpose of the disclosure.[8] Guidance from the U.S. Department of Education also notes that "without a court order or written consent, [educational] institutions that are involved in litigation between the institution and the student should not share, without consent, student medical records with the institution's attorneys or courts unless the litigation in question relates directly to the medical treatment itself…and even then should disclose only those records that are relevant and necessary to the litigation."[9] This guidance also notes that "FERPA's school official exception to consent should be construed to offer protections that are similar to those provided to medical records in the context of litigation between a covered health care provider, such as a hospital, and a patient under [HIPAA]."[10]

CONCLUSION

The patient should always be at the center of any privacy policy adopted by the AMA, and indeed, the AMA has strong policy protecting the privacy of patient information, included in the appendix. Regardless of the clinical care setting, whether it is an educational setting, a substance abuse clinic, or a physician's office, the AMA should continue to advocate for HIPAA's privacy protections to be the minimal level of privacy afforded to a patient. This position will permit more stringent privacy laws for patients where appropriate—for example, more protective state laws or federal laws, such as 42 CFR Part 2, which protects patients who seek treatment at substance abuse facilities. The AMA should also continue to ensure that any information disclosed without a patient's written consent is the minimum necessary to accomplish the disclosure's intended purpose.

RECOMMENDATIONS

The Board of Trustees recommends that Policy H-315.983 be amended in lieu of Resolution 237-A-17 and the remainder of the report be filed:

H-315.983, "Patient Privacy and Confidentiality"
Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

REFERENCES

1. 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
2. 34 CFR 99.30. 20 USC 1232g(b); 20 USC 1232g(d).
3. 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
4. 34 CFR 99.3; 20 USC 1232g(a)(4)(B)(iv).
5. *See* Joint Guidance on the Application of the *Family Educational Rights and Privacy Act (FERPA)* And [sic] the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* To Student Health Records (November 2008), p. 8, available at https://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf, accessed February 25, 2018.
6. 34 CFR 99.31; 20 USC 1232g(b).
7. 45 CFR 164.502(a).
8. 45 CFR 164.502(b); 45 164.514(d); *see also* "May a covered entity that is a plaintiff or defendant in a legal proceeding use or disclose protected health information for the litigation?", available at www.hhs.gov/hipaa/for-professionals/faq/705/may-a-covered-entity-in-a-legal-proceeding-use-protected-health-information/indes.html, accessed February 25, 2018.
9. *See* Dear Colleague Letter to School Officials at Institutions of Higher Education, U.S. Department of Education (August 24, 2016), p. 2, available at https://studentprivacy.ed.gov/sites/default/files/resource_document/file/DCL_Medical%20Records_Final%20Signed_dated_9-2.pdf, accessed February 25, 2018.
10. See Dear Colleague Letter to School Officials at Institutions of Higher Education, U.S. Department of Education (August 24, 2016), p. 2, available at https://studentprivacy.ed.gov/sites/default/files/resource_document/file/DCL_Medical%20Records_Final%20Signed_dated_9-2.pdf, accessed February 25, 2018.

APPENDIX — AMA POLICY

Policy H-315.983, "Patient Privacy and Confidentiality"
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

Policy H-320.994, "Confidentiality"
Our AMA believes that: (1) there has been an erosion of the confidential relationships between the patient and health professional, which has resulted from growing outside demands for the information shared in this relationship for the purpose of patient care; (2) there is a need to sensitize the public to the intrusions into confidential medical information which can result from increased demands for accountability - in substantiating health insurance claims, in litigation, and in medical care evaluation; (3) much of the erosion has emanated from the public, and properly so; however, an over-emphasis on society's right to know, at the expense of the individual's right to privacy and confidentiality, has resulted and a better balance is needed; (4) one important contribution to restoring such balance would be greater education of patients and the public as to the full range of

purposes for which confidential information is used, the policies governing the release of such information, and the individual's rights with respect thereto.

Policy H-315.975, "Police, Payer, and Government Access to Patient Health Information"
1. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.
2. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.
3. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.
4. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.
5. Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Policy H-60.965, "Confidential Health Services for Adolescents"
Our AMA: (1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law; (3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care; (4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements); (5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician; (6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice; (8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

Policy H-315.965, "Modernizing Privacy Regulations for Addiction Treatment Records"
Our AMA supports: (1) regulatory and legislative changes that better balance patients' privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders; (2) regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders; and (3) continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system.

17. EVALUATING ACTIONS BY PHARMACY BENEFIT MANAGER AND PAYER POLICIES ON PATIENT CARE

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
                 REMAINDER OF REPORT FILED
                 See Policies H-95.932, H-95.990 and H-120.924

INTRODUCTION

At the 2017 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-120.935, "Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care," which directed the AMA to:

(1) Take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.

(2) Work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to:

(a) Identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine, and
(b) Prohibit pharmacy actions that are unilateral medical decisions; and

(3) Report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination.

This report summarizes actions that the AMA has taken to preserve physician autonomy, highlights relevant AMA policy, and presents policy recommendations. Because the intent of the resolution and reference committee testimony primarily focused on situations related to the prescribing and dispensing of opioid analgesics, this report will similarly focus on that issue.

DISCUSSION

The AMA has been working closely with the nation's leading pharmacy and pharmacist organizations for years in support of the therapeutic triad, that is, working to enhance the collaborative roles of physicians, pharmacists and patients to help ensure safe and appropriate medication use. With respect to prescriptions for opioid analgesics, the AMA began receiving increasing reports about pharmacists contacting physicians to request additional information about patient prescriptions for controlled substances (before they would authorize dispensing) as far back as 2013. In response, the AMA and the National Association of Boards of Pharmacy organized a series of discussions with multiple stakeholders designed to increase awareness of factors contributing to these types of requests and to improve communication channels. Participating organizations included:

- American Academy of Family Physicians
- American College of Emergency Physicians
- American Medical Association
- American Osteopathic Association
- American Pharmacists Association
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Cardinal Health
- CVS Health
- Drug Enforcement Administration
- Federation of State Medical Boards
- Healthcare Distribution Management Association
- National Association of Boards of Pharmacy

- National Association of Chain Drug Stores
- National Community Pharmacists Association
- Pharmaceutical Care Management Association
- Rite Aid
- Walgreen Co.

The stakeholders initially met in October 2013, and subsequently met numerous times over the course of 2013 and 2014 to better understand the shared responsibilities of physicians and pharmacists to ensure that all controlled substances are prescribed and dispensed for a legitimate medical purpose. The stakeholders' focus began with a review of a key provision within the Controlled Substances Act, which provides:

> A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. *The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription.* An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.[1] (emphasis added)

Participants engaged in a constructive dialogue and ultimately agreed and released a consensus statement (signed by nearly all of the organizations) about the challenges that physicians and pharmacists face in trying to understand and resolve "red flags" that may be apparent, and a broader array of aberrant behaviors that may manifest and raise concerns among physicians. Commonly agreed upon "red flags" have been constructed out of U.S. Drug Enforcement Administration (DEA) administrative actions and most are obvious, such as a clearly forged prescription or multiple people from out-of-state presenting prescriptions for large quantities of high-dose opioid analgesics. However, some behaviors (e.g., slurred speech, exhibiting signs of intoxication) or specific features of the prescription including drug combinations may raise questions for the pharmacist that may be unresolvable without obtaining further information from the prescribing physician. In these cases, the organizations agreed that inter-professional dialogue was essential to resolve questions to the patient's benefit.[2]

Stakeholders shared the consensus statement widely with the intent of increasing understanding of the shared legal responsibilities of physicians and pharmacists for controlled substance prescriptions.[3] Subsequently, when the AMA received complaints from state medical societies or individual physicians, staff have enabled on multiple occasions direct collaboration between a retail pharmacy and the state medical society to investigate and intercede with the individual pharmacist or prescriber when necessary. An overarching goal is to ensure that legitimate inquiries by a pharmacist about a patient's diagnosis or medical history that are necessary to fulfill their corresponding legal responsibility are not perceived as intrusive or unnecessary, and to foster communications that can help resolve potential contraindications and/or provide physicians with relevant information in a patient's prescription history about which the physician may not be aware. Without question, such discussions can sometimes be challenging.

Publication of the *Centers for Disease Control Guideline For Prescribing Opioids For Chronic Pain[4]* (CDC Guidelines) in March 2016, has changed the regulatory and clinical practice environment and led to new challenges for pain management and opioid prescribing, including the likelihood that some patients will have their prescriptions for opioid analgesics dispensed as written. Two of the CDC Guideline's recommendations—which were developed as voluntary guidance and not a bright line threshold, according to CDC—make specific reference to prescriptions above a certain morphine milligram equivalent amount (Recommendation 5)[5] and above a certain quantity (or days' supply) (Recommendation 6).[6] In comments to the CDC during the review period, the AMA expressed specific concerns[7] about the unintended consequences of such thresholds—highlighting that future payer and legislative actions would likely align with the CDC Guidelines in ways that would not be patient centric.

Since the publication of the CDC Guidelines, more than 20 states have enacted opioid prescribing limits that include specific dose and/or quantity thresholds. What is notable is that nearly every state prescribing restriction is different, although most purport to have exceptions for patients with cancer; those who are in hospice or receiving palliative care; at end of life; or when the opioid is part of a treatment regimen for a substance use disorder. Furthermore, it is notable that opioid prescribing appears to have reached its zenith in 2012 (259 million prescriptions) with modest decreases every year since yielding a cumulative 17 percent decrease, between 2012 to 2016 (215 million

prescriptions). It is beyond the scope of this report to analyze the lack of correlation between decreased opioid prescribing and increased opioid-related mortality, but the AMA remains deeply concerned that policymakers' focus continues to be on reducing opioid supplies, with little or no emphasis on increasing access to multidisciplinary pain care, including non-opioid, and non-pharamcologic alternatives.

In addition to state laws that govern prescribing behavior, there has been significant activity by payers, pharmacies, and pharmacy benefit managers (PBMs) to adopt and implement opioid prescribing restrictions based on CDC Guidelines, including new policies in 2017 from the nation's largest PBMs, CVS Caremark, Express Scripts, and Optum.[8] This is in addition to prescription review policies that were previously implemented by pharmacies. Many payers also have instituted new prior authorization policies based on CDC Guidelines, including many state Medicaid plans, Blue Cross Blue Shield plans, and plans sponsored by United Health Care, Anthem, Aetna, Cigna, and others. In each case, the pharmacies, PBMs, and payers affirm their commitment to ending the opioid epidemic through increased vigilance regarding opioid prescribing, and many of the plans have touted their success in reducing opioid prescribing. The Board notes that the inevitable effect of any statutory, regulatory or other policy to restrict a practice will, in fact, lead to such a restriction. What is less clear, however, is whether the restrictive policies have had a concomitant effect of improving patients' pain care, or (and beyond the scope of this report) whether those policies have helped identify patients at risk of overdose and referred them to treatment for a potential substance use disorder.

The AMA continues to work with pharmacy associations and business entities, including asking the central question about whether the new policies are helping patients. The actions by pharmacies, is in addition to legislative and regulatory activity limiting quantity and dose of opioid analgesics, and in some cases, benzodiazepines. While the AMA remains concerned by actions to apply one-size-fits-all solutions to the opioid epidemic, we are cognizant that many state medical societies have been deeply engaged in the legislative process to help craft the resulting laws. Pharmacy, PBM, and payer policies, however, have not received the benefit of public notice or comment.

When comment is sought—such as through the federal government—the AMA makes its concerns clear. One of the most recent examples was in response to the Centers for Medicare & Medicaid Services (CMS) request for comment on a new electronic quality measure (eCQM) focused on the degree of potential opioid overuse, and using 90 morphine milligram equivalents as the quality measure standard, the AMA on February 9, 2018 emphasized[9]:

> Identifying those patients for whom opioid prescriptions exceed => 90 morphine milligram equivalents (MME)/day may serve as an indicator of whether a patient is at risk of overdose and should be co-prescribed naloxone, but the AMA believes that significant revisions and testing are required prior to implementing this measure in any federal program. The measure as constructed implies that patients who do not receive => 90 MME/day over a 90-day period receive higher quality care. We do not believe that the measure, with its broad denominator population and limited exclusions, adequately captures the recommendations from the CDC.[10] The recommendations allow for physicians to document a clinical rationale or justification when 90 MME/day is exceeded; yet, the measure does not capture if a justification exists nor does it provide a well-defined and targeted denominator.

While it is not yet known when CMS will publish the final measure, the AMA has and will continue to stress the need for clinical decisions to have a clear rationale informed by the best available evidence[11]. Furthermore, use of the CDC Guidelines in this manner is also inconsistent with the intended use of the Guidelines.

For example, the CDC Guidelines states:

> Clinical decision making should be based on a relationship between the clinician and patient, and an understanding of the patient's clinical situation, functioning, and life context. The recommendations in the guideline are voluntary, rather than prescriptive standards. They are based on emerging evidence, including observational studies or randomized clinical trials with notable limitations. Clinicians should consider the circumstances and unique needs of each patient when providing care.

Additionally, the AMA has actively engaged with multiple pharmacies, public health, and other organizations to advance policies increasing access to naloxone. It should be noted that the Board and AMA Council on Legislation first approved AMA model state legislation, the Help Save Lives from Overdose Act, in 2013, and revised and updated the model bill in subsequent years. In partnership with more than two dozen state medical societies,

pharmacy associations, and other stakeholders ranging from the Federation of State Medical Boards, National Association of Boards of Pharmacy, Walgreens, CVS, National Governors Association, and many others, the AMA model bill—or similar versions—are now law in every state in the nation. This type of collaborative effort has undoubtedly saved tens of thousands of lives. At the same time, the AMA continues to hear reports that some patients may not be able to afford naloxone due to the cost, lack of awareness of patient assistance programs or the ongoing stigma associated with naloxone. The AMA will continue to work to address these barriers to care so that when a patient needs access to naloxone, it will be available.

The AMA also has engaged in efforts by the National Association of Insurance Commissioners (NAIC) to revise their model legislation on the pharmacy benefit. AMA staff worked closely with other stakeholders, including many consumer and patient organizations, to advocate for the need to regulate utilization review (e.g. pharmacy benefit managers) that delay or decrease access to patient care and stand in the middle of the patient-physician decision making process. Additionally, AMA staff sought provisions that prevented continual formulary changes and other cost-saving tactics by payers that undercut physicians' ability to ensure patients receive appropriate care. While many positive provisions supported by the AMA were incorporated into the final NAIC model, much work remains to be done as state legislatures consider pharmacy benefit regulations.

As such, the AMA has developed model legislation to address the issues of prior authorization, step therapy and other utilization management programs that have regularly impeded the practice of medicine by physicians, and just this year alone, is working with nearly a dozen state medical societies on state bills.

Additionally, over the last year the AMA has assembled a multi-stakeholder group that created a set of highly cited and widely distributed principles on utilization management reforms,[12] all aimed at right-sizing payer involvement in patient care. In addition to policy discussions and changes that these principles have informed, they also served as the basis for a recent consensus statement[13] among the American Medical Association, Blue Cross Blue Shield Association, America's Health Insurance Plans, American Pharmacists Association, American Hospital Association, and Medical Group Management Association on the need to reform prior authorization programs and processes.

More broadly, the AMA also has engaged with the National Association of Insurance Commissioners and others to support notification of patients and physicians before a health insurance company or PBM may change a patient's prescription. This situation often occurs as a PBM restricts a formulary during a patient's plan year. In 2017, two of the nation's two largest pharmacy benefit managers – Express Scripts and CVS/Caremark, which set the coverage for many health insurers – continue to aggressively remove medications from their formularies[14].

When health insurers or PBMs decide to exclude certain products, or increase the patients' cost-sharing, patients are forced to switch to a new medication, which may or may not be as effective. And if the patient wishes to continue taking the medication that he or she used to stabilize a medical condition, the off-formulary cost may not be affordable – and it will not count towards the patient's deductible. These types of forced-switching and increased patient cost-sharing are associated with declines in medication adherence, which in turn can lead to poorer patient health outcomes. In some cases, patients are forced to choose between necessary treatments and decisions such as expenses for food or shelter.

For physicians and patients, when a prescription for an opioid analgesic—or any other medication—is denied at the pharmacy counter, there may be multiple reasons. In some cases, as described above, the health insurance company or the PBM may be applying a hard edit associated with limits based on the CDC Guidelines. In other cases, it may be the pharmacy chain policy that determines what the pharmacist may dispense. In these situations, the pharmacist is placed in the difficult position of having to inform the patient, and often, the physician, that the original prescription will not be filled. In other cases, also described above, the pharmacist may determine—per his or her lawful exercise of the pharmacist's corresponding responsibility—that the prescription was not issued for a legitimate purpose in the usual course of professional practice.

In these situations, if the pharmacist communicates with the physician to determine how to proceed, this will take time away from the physician's practice and the pharmacist's ability to help more patients. The AMA supports physician-pharmacist interactions to ensure patient safety, but in some cases, the decision has been taken out of the pharmacist's control—frustrating the physician, pharmacist and likely adversely affecting the patient. And even when the communication from the pharmacist to the physician is to resolve important questions, there still may be

frustration due to having to take time away from patient care or return a call to the pharmacy, which may result in the physician being placed on hold for an extended period—further delaying and impeding patient care.

AMA POLICY

The AMA supports patients having access to the medications prescribed to them by their physician without interference into the practice of medicine (H-120.947, "Preserving Patients' Ability to have legally Valid Prescriptions Filled"; D-35.981, "AMA Response to Pharmacy Intrusion Into Medical Practice"). For controlled substances, this policy must be tempered with the recognition that pharmacists share a corresponding responsibility that carries the same legal obligations and risks for failure to comply. In addition, AMA policy states opposition to "pharmacists being given the authority to initiate or modify prescription drug treatment except on a case by case basis at the specific direction of a physician" (H-160.928, "Drug Initiation or Modification by Pharmacists"). At the same time, the AMA recognizes that "cooperative relationships with law enforcement, regulatory agencies, pharmacists, and other professional groups" are necessary to identify situations where a person is attempting to obtain a prescription for fraudulent or otherwise illegal means (H-95.990, "Drug Abuse Related to Prescribing Practices"). Similarly, AMA policy "supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies" (H-95.932, "Increasing Availability of Naloxone"). It is worth noting that AMA advocacy, including development of model state legislation based on Policy H-95.932, has helped lead to enactment of naloxone access laws in all 50 states. AMA policy strongly supports "private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing." (H-95.932, "Increasing Availability of Naloxone").

AMA policy is clear that health insurance carriers and PBMs must provide accurate information to patients at the time when plans are put forward for review by consumers. (H-125.979, "Private Health Insurance Formulary Transparency"). Furthermore, H-125.979 clearly states that "drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term." In addition, AMA policy supports "forbidding insurance carriers from making formulary deletions within the policy term." In the event that an insurer or PBM does make a change, AMA policy calls for "notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours." As directed by our HOD, the AMA has drafted model state legislation to accomplish these goals, and the AMA strongly urges state medical societies to work with the AMA to introduce and enact the AMA model state legislation.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) urge the National Association of Boards of Pharmacy, Federation of State Medical Boards, and National Association of Insurance Commissioners (NAIC) to support having national pharmacy chains, health insurance companies, and pharmacy benefits managers (PBMs) testify at state-level public hearings by state medical/pharmacy boards and state departments of insurance on whether the pharmacy chains, health insurance companies, and PBMs' policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state insurance laws or state laws governing the practice of medicine and pharmacy.

2. That our AMA oppose specific dose or duration limits on pharmacologic therapy that are not supported by medical evidence and clinical practice.

3. That our AMA reaffirm Policy H-95.990, "Drug Abuse Related to Prescribing Practices," which supports cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups as necessary to identify situations where a person is attempting to obtain a prescription for fraudulent or otherwise illegal means.

4. That our AMA reaffirm Policy H-95.932, "Increasing Availability of Naloxone," which supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies.

REFERENCES

1. United States Drug Enforcement Administration. 21 CFR §1306.04 Purpose of issue of prescription. Available at www.gpo.gov/fdsys/pkg/CFR-2014-title21-vol9/pdf/CFR-2014-title21-vol9-sec1306-04.pdf

2. Stakeholders' Challenges and Red Flag Warning Signs Related to Prescribing and Dispensing Controlled Substances, available at https://www.ama-assn.org/system/files/media-browser/public/arc/prescribing-dispensing-controlled-sustances-summary-consensus_0.pdf

3. Stakeholders identify prescribing and dispensing challenges. AMA Wire.March 24, 2015. Available at https://wire.ama-assn.org/practice-management/stakeholders-identify-prescribing-and-dispensing-challenges

4. CDC Guideline For Prescribing Opioids For Chronic Pain, March 18, 2016. Available at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

5. Recommendation 5 of the CDC Guideline states: "When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day."

6. Recommendation 6 of the CDC Guideline states: "Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed (recommendation category."

7. AMA letter to Thomas Frieden, MD, MPH, Director, Centers for Disease Control and Prevention, Re: Docket No. CDC-2015-0112; Proposed 2016 Guideline for Prescribing Opioids for Chronic Pain. January 12, 2016. Available at https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fopioid-cdc-letter-01oct2015.pdf

8. See, for example, "CVS tightens restrictions on opioid prescriptions in bid to stanch epidemic," stat news, September 21, 2017. Available at https://www.statnews.com/2017/09/21/cvs-opioid-prescription-limits/; OptumRx "Quantity Limit Changes On Short Acting Opioids." Available at https://professionals.optumrx.com/content/dam/optum3/professional-optumrx/resources/pdfs/Quantity%20Limit%20Changes%20on%20Short%20Acting%20Opioids_Provider%20Portal_v20170613_vf.pdf; "Express Scripts Limits on Opioids Rankles Physicians," Medscape. August 22, 2017. Available at https://www.medscape.com/viewarticle/884557

9. AMA letter to Seema Verma, "Electronic Clinical Quality Measure (eCQM) Development and Maintenance for Eligible Professionals (EP eCQM) Potential Opioid Overuse-Contract Number HHSM-500-2013-13011I/HHSM-500-T0001. February 9, 2018. Available at https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-2-9-Letter-to-Verma-re-Comments-on-Potential-Opioid-Use-eCQM.pdf

10. Centers for Disease Control & Prevention. Guideline for Prescribing Opioids for Chronic Pain. 2016. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

11. See, for example, March 3, 2017, AMA letter to Patrick Conway, MD, Acting Administrator, Centers for Medicare & Medicaid Services, Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter; March 4, 2016, AMA letter to Sean Cavanaugh, Deputy Administrator Centers for Medicare & Medicaid Services, Department of Health and Human Services, RE: Advance Notice of 2017 Methodological Changes for Medicare Advantage Capitation Rates, Part C and D Payment Policies and 2017 Draft Call Letter; February 20, 2015, AMA letter to Amy K. Larrick, Acting Director, Medicare Drug Benefit and C&D Data Group, Centers for Medicare & Medicaid Services, Re: Draft Revisions to Medicare Prescription Drug Benefit Manual – Chapter 6.

12. Prior Authorization and Utilization Management Reform Principles. Available at https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf

13. Consensus Statement on Improving the Prior Authorization Process. Available at https://www.ama-assn.org/sites/default/files/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

14. "Pharmacy Benefit Managers Drug Exclusions." Decision Resources Group. August 29, 2017. Accessed March 15, 2018. Available at https://decisionresourcesgroup.com/drg-blog/pbm-drug-exclusions/

18. MEDICAL LIABILITY COVERAGE THROUGH THE FEDERAL TORT CLAIMS ACT
(RESOLUTION 214-A-17)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: **RECOMMENDATION ADOPTED**
                            RESOLUTION 214-A-17 NOT ADOPTED
                            REMAINDER OF REPORT FILED

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 214-A-17, "Medical Liability Coverage Through the Federal Tort Claims Act," for report back at the 2018 Annual Meeting. This resolution was introduced by the New York Delegation and asked:

> That our American Medical Association (AMA) seek legislation that would lead to malpractice insurance coverage through the Federal Tort Claims Act for all physicians who participate in Medicare and/or Medicaid and all federal insurance plans.

This report provides background on Federal Tort Claims Act (FTCA) medical liability protections and the potential implications of expanding FTCA protection to all federal health insurance plans.

FEDERAL TORT CLAIMS ACT

Congress originally enacted the FTCA in 1946 to provide immunity to federal government employees from tort liability when acting within the scope of their work. Under the FTCA, a patient of a federally employed physician who alleges acts of medical liability cannot sue the provider directly but must instead file the claim against the United States government. The federal government acts as the primary insurer and reviews and/or litigates claims via the U.S. Department of Health and Human Services (HHS) or the Department of Justice.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) extended FTCA protection to certain health professionals at qualifying free clinics, recognizing that these centers rely on volunteers to provide health services to poor and underserved patients. The Affordable Care Act expanded the FTCA liability coverage to the clinic's board members, officers, paid health professional staff, and certain health professional contract employees.

Currently, the only private physicians who are covered by the FTCA must provide free care at qualified clinics. These private physicians are volunteers and cannot accept any payment from any third party. The liability protections provided by the FTCA are strong and have ensured that physicians and other practitioners are not deterred from volunteering their services at free clinics.

To be eligible for this comprehensive protection, private physicians must comply with explicit statutory requirements. Specifically, the clinic must be operated by a nonprofit entity, not accept reimbursement for providing health care services from any third-party payor (but may accept voluntary donations), and only impose charges on patients according to their ability to pay. Similarly, the professional must be appropriately licensed or certified, may not receive compensation from the patients directly or from any third-party payor, and must provide patients with written notification of the limited liability prior to providing services.

DISCUSSION

The existing medical liability system continues to drain health care resources that could be devoted instead to improving quality of care and access for patients. Additionally, medical liability places many physicians at unnecessary emotional, reputational, and financial risk. While expanding FTCA coverage for all physicians who participate in federal health care programs may alleviate high medical liability insurance premiums in certain states, such a broad expansion of the federal government's sovereign immunity would overall have large consequences across the practice of medicine and could conflict with existing, long-standing, and successful AMA policy on medical liability reform. Based on Medicare alone, Resolution 214-A-17 would impact almost 90 percent of the practicing physicians in the United States.[1] In addition, this protection would cover 37 cents of every dollar of health expenditures in the United States.[2]

Under Resolution 214-A-17, physicians would have no control over the direction of a medical liability case involving a Medicare, Medicaid, or other federal health insurance patient. In a FTCA case, the federal government represents the physician. Thus, physicians would have no choice as to what attorney represents their medical liability case and no ability to decide whether a case goes to trial or is settled, and, in turn, reported to the National Practitioner Data Bank (NPDB). Any court judgments or settlements resulting from medical liability cases are reviewed by HHS' Medical Claims Review Panel and are reportable to the NPDB. The Panel is a peer review group of federal employees that includes medical staff from HRSA and other HHS agencies and is responsible for: (1) making a final determination as to whether the standard of care was met or not met; and (2) identifying the clinician(s) who provided the treatment giving rise to the claim. If the Panel determines the standard of care was not met, the named practitioner(s) will be reported to NPDB.

Currently, in the private sector, FTCA coverage only applies to health care providers who provide free care at certain facilities, which is supported by AMA policy.[3] Neither the health care provider nor the institution can receive any third-party reimbursement for services rendered (e.g., public or private health insurance). The congressional intent behind expanding the FTCA to these health care providers was to increase the funds available to free clinics without increasing their budgets in order to provide more free care to patients and to encourage volunteerism.[4] In expanding FTCA coverage to all federal health insurance patients, maintaining the requirement of providing free care and not accepting any payment from any health insurance would be impractical for many physicians. Alternatively, allowing for reimbursement from insurance and FTCA protection would be a significant departure from previous federal policymakers' intent in expanding access to free care and to promote volunteerism. Moreover, such Medicare reimbursement may be decreased because the physician fee schedule payment rate formula includes a Malpractice Resource Value Unit which is intended to reflect the costs of liability insurance.

Resolution 214-A-17 may conflict with AMA policy on medical liability reform. Existing AMA policy is focused on supporting initiatives implementing reforms based on California's Medical Injury Compensation Reform Act (MICRA)[5] and additional reforms like certificate of merit and expert witness requirements. Moreover, AMA policy expressly states that the AMA "actively oppose" any federal initiatives that endanger state-based reform.[6] Thus, if expanding the FTCA to cover all physicians who participate in Medicare, Medicaid, and all federal health insurance plans endangers state-based reform efforts, AMA policy would lead the AMA to actively oppose such a federal initiative. In allowing for the federal government's sovereign immunity to pass through to virtually all private physicians, state-based reforms may be endangered. Given that the FTCA requirements include both federal and state administrative and legal requirements, there is a substantial risk that applying the FTCA to any health care services that are federally funded could undermine comprehensive medical liability reforms at the state level. For example, any state procedural or evidentiary rules could be superseded by the Federal Rules of Civil Procedure and the Federal Rules of Evidence. Thus, a state evidentiary rule that makes a physician's apology to a physician inadmissible in that state's courts may not apply to a FTCA case and the apology could be introduced into evidence.

Even if states or individual physicians can opt-out of FTCA coverage, there could still be negative consequences. If a medical liability case involves an opted-out physician and a FTCA-covered physician, the federal government can bar the FTCA-covered physician from testifying to any aspect of the case.[7] Finally, there is no evidence that reflects that physicians and patients would be better off under the universal application of the FTCA than under comprehensive state medical liability reforms like California's MICRA or Texas' similar law.

The Board has previously considered this issue. At the 2009 Annual Meeting, Resolution 226-A-09, "Revision of the Federal Tort Claims Act," also introduced by the New York Delegation, was referred to the Board for decision. Similar to 214-A-17, the resolution asked our AMA to act on the proposal to extend the FTCA to any claim and/or health care service that is funded in whole or in part by federal funds (e.g., Medicare, Medicaid, etc.). The Board considered the resolution at its November 2009 meeting and decided, in lieu of adopting Resolution 226-A-09, to issue an informational report (Board Report 24-A-10, "Revision of Federal Tort Claims Act") explaining the implications of a broad application of the FTCA. The Board concluded:

> There is no evidence, however, that universal application of the FTCA will reduce the filing of meritless cases. In addition, expansion of the jurisdiction of the FTCA could undermine effective medical liability reform already in place in certain states, including California and Texas. An alternative to widespread application of the FTCA would be to assess the benefits of extending FTCA coverage through demonstrations at the state level or in particular settings such as federally qualified health centers.

Since this report, there remains no evidence that universal application of the FTCA will reduce the filing of meritless cases.

Furthermore, at the 2011 Annual Meeting, Resolution 204-A-11, "Sovereign Immunity for EMTALA-Related Care," was referred to the Board for decision. This resolution called for FTCA coverage for EMTALA mandated care. Similar to Resolution 226-A-09, there was mixed testimony weighing the potential benefits of FTCA coverage against the potential negative effects for physicians, including loss of control over settlement decisions and increased NPDB reporting. The Board considered Resolution 204-A-11 at its November 2011 meeting and decided to amend policy D-130.971, "The Future of Emergency and Trauma Care," by adding a statement that our AMA will "support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care." Since this decision, there have been no demonstration programs implemented.

The Board believes that the AMA, along with the state and specialty medical associations, should continue to pursue both traditional and innovative medical liability reforms to strike a reasonable balance between the needs of patients who have been harmed and the needs of millions of Americans who need affordable, accessible medical care.[8] Traditional reform includes efforts at both the state and federal levels to enact or maintain reasonable limits on subjective non-economic damages. Innovative reforms include concepts like health courts, early disclosure and compensation models, expert witness guidelines, and affidavits of merit.

Given the lack of evidence that the application of the FTCA will benefit physicians, the Board concludes that Resolution 214-A-17 should not be adopted. If an FTCA coverage demonstration program were to occur that could show that FTCA coverage would benefit physicians, current AMA policy would support such a demonstration program as an innovative medical liability reform.

RECOMMENDATION

The Board of Trustees recommends that Resolution 214-A-17 not be adopted and the remainder of the report be filed.

REFERENCES

1. CMS, CMS Fast Facts, *Medicare Non-Institutional Providers by Specialty* (2018) (stating that 662,619 physicians were enrolled in Medicare in 2016); IQVIA, *The National Economic Impact of Physicians National Report* (2018) (stating that 736,873 were providing patient care in December 2015).
2. CMS, *National Health Expenditures Accounts* (2016). Total national health expenditures (which includes out of pocket expenses) for 2016 totaled $3,337,348,000,000. Resolution 214-A-17 calls for FTCA protection under Medicare, Medicaid, and other federal health insurance expenditures. We interpret "other federal health insurance" to include CHIP. We did not include the Federal Employees Health Benefits program because it is considered private insurance and did not include Tricare or Champva because the majority of the physicians providing care receive FTCA protection as federal employees. Medicare, Medicaid, and CHIP health expenditures for 2016 totaled $1,254,526,000,000.
3. AMA Policy H-160.940 (Free Clinic Support); AMA Policy D-435.969 (Liability Related to Referrals from Free Clinics); Report of the Council of Medical Service, *Free Clinics and the Uninsured*, Report 1-A-09.
4. E.g., OIG, *Cost to the Government for Providing Medical Malpractice Coverage to Community and Migrant Health Centers*, A-04-95-0208 (1996); H. Rep. No. 111-220 (2009); S. Rep. No. 113-71 (2013).
5. The MICRA model includes a limitation of $250,000 on non-economic damages, mandatory offset of collateral sources of plaintiff compensation, decreasing sliding scale regulation of attorney contingency fees, and periodic payment for future awards of damages.
6. AMA Policy H-435.978 (Federal Medical Liability Reform), AMA Policy H-435.967 (Report of the Special Task Force and the Advisory Panel on Professional Liability).
7. 45 C.F.R. Part 2.
8. AMA Policy H-435.978 (Federal Medical Liability Reform); AMA Policy H-435.967 (Report of the Special Task Force and the Advisory Panel on Professional Liability); AMA Policy D435.992 (Liability Reform); AMA Policy D-435.974 (Health System and Litigation Reform).

APPENDIX – Current AMA Policy

Policy D-435.969, "Liability Related to Referrals from Free Clinics"
That our American Medical Association will work with interested medical associations to enact state legislation that provides medical liability immunity, similar to the protections granted under the Federal Tort Claims Act (FTCA), to physicians who provide charity care in hospitals, offices, clinics or other health care settings to patients referred from free clinics.

Policy H-160.940, "Free Clinic Support"
Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions.

Policy H-435.978, "Federal Medical Liability Reform"
Our AMA: (1) supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of $250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages; (2) reaffirms its support for the additional reforms identified in Report L (A-89) as appropriate for a federal reform vehicle. These are: (a) a certificate of merit requirement as a prelude to filing medical liability cases; and (b) basic medical expert witness criteria; (3) supports for any federal initiative incorporating provisions of this type would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. Federal preemptive legislation that endangers state-based reform will be actively opposed. Federal initiatives incorporating extended or ill-advised regulation of the practice of medicine also will not be supported. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.

Policy H-435.967, "Report of the Special Task Force and the Advisory Panel on Professional Liability"
1. It is the policy of the AMA that effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. The AMA's MICRA-based federal tort reform provisions include: (a) a $250,000 ceiling on non-economic damages, (b) the offset of collateral sources of plaintiff compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d) periodic payment of future awards of damages, and (e) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth.
2. Our AMA also supports federal reform to achieve: (a) a certificate of merit requirement as a prerequisite to filing medical liability cases; (b) statutory criteria that outline expert witness qualifications; and (c) demonstration projects to implement potentially effective alternative dispute resolution (ADR) mechanisms.
3. Our AMA supports medical product liability reform, applicable to the producers of pharmaceuticals and medical devices, as an important state and federal legislative reform objective.
4. Any health system reform proposal that fails to include MICRA type reform, or an alternative model proven to be as effective in a state, will not be successful in containing costs, providing access to health care services, and promoting the quality and safety of health care services. Under no circumstances would support for federal legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states. Federal preemptive legislation that endangers effective state-based reform will be actively opposed.

Policy D435.992, "Liability Reform"
Our AMA: (1) in concert with a coalition for civil liability reform, shall develop a broad-based and sustained grassroots member mobilization campaign to communicate its call for immediate legislative relief from the current tort system to our congressional representatives and senators; (2) will work for passage of significant legislation in both houses of the US Congress on liability reform in this congressional year; and (3) will work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process.

Policy D-435.974, "Health System and Litigation Reform"
Our AMA will (1) press vigorously and creatively for inclusion of effective medical litigation reforms as part of the comprehensive federal health system/insurance reform debate now underway in Washington, DC; and (2) consider and, as necessary, negotiate with federal policymakers on a wide range of litigation reform policy options to gain inclusion of a remedy in the health system reform package. These options might include traditional tort reforms, recovery limitations similar to those of the Veterans Administration (VA) system, demonstration/pilot programs on alternate dispute resolution systems such as the VA model and health courts, and/or other effective options to preserve patient access to care.

19. HEALTH INFORMATION TECHNOLOGY PRINCIPLES
(RESOLUTION 218-I-17)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED AS FOLLOWS**
                      IN LIEU OF RESOLUTIONS 218-I-17
                      REMAINDER OF REPORT FILED
                      See Policies H-478.981, H-480.971, D-478.972, D-478.973, D-478.994.
                      D-478.995 and D-478.996

INTRODUCTION

At the 2017 Interim Meeting Resolution 218-I-17, "Health Information Technology Principles," was referred by the House of Delegates. Resolution 218-I-17, introduced by the Organized Medical Staff Section, asks the American Medical Association (AMA) to adopt and promote the development of effective electronic health records (EHR) in accordance with the following health information technology principles:

1. Whenever possible, physicians should have direct control over choice and management of the information technology used in their practices.
2. Information technology available to physicians must be safe (e.g., electronically secure, and in the case of distributed devices, physically so), effective, and efficient.
3. Information technology available to physicians should support the physician's obligation to put the interests of patients first.
4. Information technology available to physicians should support the integrity and autonomy of physicians.
5. Information technology should support the patient's autonomy by providing access to that individual's data.
6. There should be no institutional or administrative barriers between physicians and their patients' health data.
7. Information technology should promote the elimination of health care disparities.
8. The cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules on an ongoing basis; payments should ensure sustainability of such systems in practice.

This resolution was referred for report back at the 2018 Annual Meeting.

BACKGROUND

Health information technology (HIT), specifically EHRs, has been plagued with numerous usability, flexibility, and security issues that have negatively impacted the end-user experience. These issues have contributed to high levels of physician burnout and a diminished patient-physician relationship.[1-3] Physicians have been vocal about their frustration with these systems and their lack of input into the decision process when purchasing and implementing them in practice. To successfully implement and gain widespread adoption of HIT, physician input and buy-in is crucial.[2, 4]

Data issues are commonly cited as a point of dissatisfaction. Physicians are often unable to find the data they need when they need it. It is also not delivered in a way that fits within their workflow or documentation procedures. Another common complaint is that their documentation practices are established in response to external drivers versus what is truly necessary and important to the care of the patient.[2]

Lack of interoperability is also a source of discontent for many physicians. This is a multifactorial, complex issue that involves cooperation and dedication from many key stakeholders including government, vendors, and health systems. Cost, competing priorities, and misaligned incentives contribute to barriers in achieving full interoperability across health care, negatively impacting the front-line of care.[3]

The AMA has been successful in making progress toward improving and advancing EHRs and HIT through advocating for policy and collaborating with stakeholders. This resolution proposes further allegiance to this work

through formal adoption of clear and concise principles for technology-enabled solutions to ensure physician input is included in the development and use of HIT, specifically EHRs, to improve both the physician and patient experiences.

AMA POLICY

The AMA is committed to working with federal and state agencies, policymakers, and other relevant stakeholders to improve EHRs and advance HIT. The AMA encourages physician involvement in defining, evaluating, and implementing EHRs for improved usability, access, and security (Policy H-480.971, "The Computer-Based Patient Record").

The AMA is steadfast in its efforts to improve EHR usability and enhance access to data for both physicians and patients. The AMA works with the Office of the National Coordinator for Health Information Technology (ONC) and EHR vendors to support interconnectivity and interoperability enabling the efficient and cost effective use and sharing of data across all care settings (Policy D-487.995, "National Health Information Technology"). The AMA also continues to support and encourage Congress to eliminate unnecessary data blocking to improve and expand the exchange of data (Policy D-478.972, "EHR Interoperability").

The AMA is committed to actively engaging with federal and state agencies, EHR vendors, and other stakeholder groups in their efforts to reduce the cost burdens often associated with EHRs. The AMA promotes EHR vendor cost transparency around implementation, maintenance, and interface production (Policy D-478.973, "Principles of Hospital Sponsored Electronic Health Records"). The AMA advocates for flexibility related to the adoption and use of HIT across versions and editions as to not cause disproportionate financial burden or penalization to physicians and practices (Policy D-478.996, "Information Technology Standards and Costs"). Additionally, the AMA supports legislation that provides positive incentives for physicians to acquire HIT (Policy D-478.994, "Health Information Technology").

DISCUSSION

Lack of physician voice in the development, evaluation, and implementation of HIT has contributed to high rates of physician dissatisfaction with HIT, specifically EHRs. Dissatisfaction among EHR end-users has contributed to physician burnout, a diminished patient-physician relationship, and unrealized cost savings.[5]

This resolution proposes eight HIT principles for the development of effective EHRs. The AMA released eight EHR usability priorities in 2014, many of which are closely aligned with the principles proposed in Resolution 218-I-17. These priorities were developed by the AMA Advisory Committee on EHR Physician Usability. Members included former president of the AMA Steven Stack, MD, chief medical information officers, practicing physicians, and medical professors. The priorities identified in 2014 by the AMA's Advisory Committee on EHR Physician Usability are as follows:

1. Enhance physicians' ability to provide high-quality patient care.
2. Support team-based care.
3. Promote care coordination.
4. Offer product modularity and configurability.
5. Reduce cognitive workload.
6. Promote data liquidity.
7. Facilitate digital and mobile patient engagement.
8. Expedite user input into product design and post-implementation feedback.

These priorities outline and support the need for better usability, interoperability, and access to data for both physicians and patients. In addition, they reaffirm the importance of considering patient care and physician input in the build and implementation related to EHRs. The AMA works to advance these goals through key stakeholder engagement (i.e., EHR vendors, health systems, and researchers), advocacy, and education. The AMA actively promotes these priorities and several vendors, including athenahealth and MEDITECH, have publicly acknowledged how their products align with these priorities.

Furthermore, these priorities have guided the AMA in its advocacy efforts to adopt and promote the development of effective HIT. For example, these efforts are demonstrated in statutory and regulatory changes made by the federal government:

21st Century Cures Act
- Creating information blocking provisions against EHR vendors including an up to $1,000,000 civil monetary penalty;
- Requiring Certified EHR IT (CEHRT) to incorporate application programing interfaces (API);
- Requiring real-world testing of EHRs;
- Prohibiting restrictions on user communications about EHR usability, interoperability, security, and developer business practices;
- Requiring EHRs to exchange data with clinician-led clinical registries;
- Prompting patient access to their longitudinal health record; and
- Requiring the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of EHRs.

ONC Enhanced Oversight and Accountability Rule
- Increasing federal oversight of EHR functionality post-certification.
- Holding health IT developers accountable to certification non-conformities including allowing for ONC corrective action plans and CEHRT certification suspension and/or termination.

ONC 2015 Edition Health IT Certification
- Requiring HIT vendors to disclose fees for EHR functions, including connecting to health information exchanges (HIE) and clinical registries;
- Increasing user-centered design (UCD), i.e., usability requirements, in CEHRT development; and
- Requiring HIT developers to use and test against advanced interoperability standards (which improves data liquidity).

The AMA's robust research agenda drives its pursuit of a strong evidence base to inform industry wide HIT innovation and the improvement of EHR development and implementation. The AMA in 2013 partnered with the RAND Corporation to study factors that affect physician professional satisfaction, which resulted in quantitative and qualitative evidence that EHRs are a major source of dissatisfaction for physicians.[2] The AMA led a comprehensive time-motion study that demonstrated for every one hour of face-to-face time with patients, physicians spend nearly an additional two hours doing EHR and administrative deskwork.[5] The AMA has also published multiple journal articles on the topic of EHRs and their contributions to physician dissatisfaction, burnout, and undue administrative burden.[3, 6-8] In addition to this established work, the AMA is currently collaborating with multiple partners to execute research planned for publication in 2018. These efforts include an observational study aimed at tracking physician actions during EHR use; an evaluation of barriers and facilitators to adoption of digital health solutions; and research aimed at identifying opportunities to improve the usability and safety of EHRs. The AMA will continue to pursue research to help stakeholders, including physicians, payers, regulators, health system leadership, and EHR vendors, make informed improvements to the EHR user experience.

In collaboration with the American Heart Association, HIMSS, and DHX Group, the AMA founded Xcertia in 2016. This collaboration is dedicated to developing guidelines that foster safe, effective, and reputable health technologies. Through engagement from a diverse group of industry stakeholders, Xcertia aims to reduce burden on providers/health care sponsors, give consumers confidence, and help technology developers bring better solutions to the market. Xcertia has already published preliminary guidelines covering four major areas—operability, privacy, security, and clinical content. As HIT solutions continue to evolve, the guidelines provided by Xcertia will be further developed to align with and be applicable to additional forms of HIT, resulting in an inclusive set of guiding principles.

The AMA has established partnerships with the SMART Initiative, AmericanEHR Partners, and Medstar Health's National Center for Human Factors in Healthcare to help foster innovative HIT design and transparent testing solutions which will ensure EHRs are designed and implemented with physicians and patients in mind. In addition, the AMA actively participates in The Sequoia Project, Carequality, and the CARIN Alliance, all aimed at enhancing interoperability in health care. The AMA is also working to address specific cost drivers, such as connecting to clinical data registries and prohibitive fees that amount to data blocking. The AMA's Physician Innovation Network

is also connecting physicians and health tech entrepreneurs to ensure that the physician voice is integrated into health care technology solutions coming to market.

The AMA is the founder and sole shareholder of Health2047, a Silicon Valley-based innovation enterprise focused on developing and commercializing solutions in the areas of data liquidity, chronic care, productivity, and payments to significantly change U.S. healthcare at the system level. Building on initial work performed within Health2047, including a collaboration with Celgene Corporation, Health2047 created Akiri Switch, a newly spun-off company that will commercialize a blockchain-based private network that enables secure permissions-based sharing of health data among patients, physicians, providers, payers, pharma and other healthcare enterprises. Through this work the AMA further demonstrates its commitment to seeking out and developing HIT solutions for the future and long-term sustainability of health care.

The AMA's eight EHR usability priorities provide clear and concise requirements for the development of effective EHRs, very similar to this resolution's proposed principles for the development of effective EHRs. Principles one through five proposed in Resolution 218-I-17 closely align with the direction provided in these established priorities.

The sixth proposed principle states that in the development of effective EHRs "there should be no institutional or administrative barriers between physicians and their patients' health data." Administrative and institutional barriers most often stem from decisions made at the organizational level, not in the development of the EHR system. Therefore, it is not recommended that AMA adopt a principle that may misrepresent the extent to which EHR developers influence or control barriers that exist between users and their administrations or institutions.

The proposed principle seven states "information technology should promote the elimination of health care disparities." Numbers one, three and seven of the eight established EHR usability priorities are "enhance physicians' ability to provide high-quality patient care; promote care coordination; and facilitate digital and mobile patient engagement." These priorities, if followed in the development of EHRs and other HIT, will enable the technology to support access to care, facilitate better patient interactions, and ultimately help address health care disparities. Since the proposed principle offers direction similarly provided in the priorities, it is not recommended to adopt this principle as separate policy.

Principle eight of this resolution asks the AMA to provide data that will convince payers to increase payment rates, essentially asking the AMA to take a position that payers are responsible for reimbursing physicians for the costs associated with implementing IT systems. Given the many facets of HIT implementation, systematic compilation of this data would be difficult given the complex state of payment models, ongoing changes with reimbursement, and variations in practice types and their unique IT needs and related costs. Additionally, the AMA previously elected to not adopt a similar resolution (813-I-16), instead resolving to focus on encouraging vendors and payers to actively work toward better, more user-friendly and cost-effective solutions that do not overburden physicians and practices.

As evidenced by the preceding discussion, the AMA currently dedicates significant resources to improving usability, enhancing interoperability, and bringing value into EHRs and HIT. The AMA's already established eight EHR usability priorities provide clear and concise requirements for the development of effective EHRs. In using these priorities, AMA has successfully advocated for the adoption and promotion of the development of effective EHRs as can be seen in the 21st Century Cures Act, ONC Enhanced Oversight and Accountability Rule, ONC 2015 Edition Health IT Certification, and in many other rules and guidance documents from the Department of Health and Human Services. Additionally, Xcertia is currently developing broader guidelines for health care technologies in the areas of content, usability, privacy, security, and operability, inclusive of many key stakeholders across the health technology landscape. Through its current work, the AMA recognizes the value of established standards and guiding principles for many aspects of health care. The AMA will continue its efforts to further develop research, content and guidance for physicians, and will regularly ensure those resources are relevant, timely, and easily accessible.

RECOMMENDATIONS

The Board of Trustees recommends that our American Medical Association adopt the following in lieu of Resolution 218-I-17, and the remainder of this report be filed:

1. That the following policies be reaffirmed:
    H-480.971, "The Computer-Based Patient Record"
    D-478.972, "EHR Interoperability"
    D-478.973, "Principles for Hospital Sponsored Electronic Health Records"
    D-478.994, "Health Information Technology"
    D-478.995, "National Health Information Technology"
    D-478.996, "Information Technology Standards and Costs"

2. That our AMA promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
    1. Enhance physicians' ability to provide high quality patient care;
    2. Support team-based care;
    3. Promote care coordination;
    4. Offer product modularity and configurability;
    5. Reduce cognitive workload;
    6. Promote data liquidity;
    7. Facilitate digital and mobile patient engagement; and
    8. Expedite user input into product design and post-implementation feedback.

3. That our AMA utilize HIT principles to:
    1. Work with vendors to foster the development of usable EHRs;
    2. Advocate to federal and state policymakers to develop effective HIT policy;
    3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
    4. Partner with researchers to advance our understanding of HIT usability; and
    5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care.
    6. Promote the elimination of "information blocking."

4. That the cost of installing, maintaining and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

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20. ANTI-HARASSMENT POLICY

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
**   REMAINDER OF REPORT FILED**
See Policy H-140.837

At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy H-140.837, "Anti-Harassment Policy" (see Appendix for full text). The policy was proffered by Board of Trustees Report 23-A-17, which provided that:

> Upon adoption of the Anti-Harassment Policy, the Board will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident. Additionally, the Board will consider and prepare for future consideration by the HOD, potential corrective action and/or discipline for conduct in violation of this policy, which may include, but shall not be limited to, referral of the matter to the applicable delegation, expulsion from AMA meetings, or expulsion from the HOD.

Board of Trustees Report 23-A-17 also noted that AMA Human Resources policies establish zero tolerance regarding harassment with respect to AMA personnel, agents, and nonemployees, including AMA members. This report of the Board of Trustees recommends procedures to fully implement the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities, such as the RVS Update Committee (RUC) and CPT Editorial Panel.

DISCUSSION

Professional associations' anti-harassment policies are designed to support the open exchange of ideas central to their mission and to ensure that those who participate in association activities "enjoy an environment free from all forms of discrimination, harassment, and retaliation" [1]. Surprisingly few professional associations have published anti-harassment policies. These associations have established mechanisms to address allegations of harassment that designate the association officer(s) or other association authority to whom incidents should be reported, provide for confidential investigation of alleged inappropriate conduct, and define sanctions that may be imposed if conduct is found to violate association policy [1-5].

The Board notes that the AMA's existing mandatory recurring anti-harassment training includes not only staff, but also members of the Board and all AMA councils and section governing councils. It is the Board's hope that this training will educate AMA leaders on what is and is not acceptable behavior, to help ensure the absence of harassing behavior in connection with meetings of AMA entities. However, given our zero tolerance policy for such behavior, we believe that a formal process for reporting, investigation and resolution should be established.

AMA Human Resources Policy 015 provides that a complaint of harassment by an AMA staff member be reported immediately to the Senior Vice President of Human Resources or the Executive Vice President for investigation and appropriate action. AMA Human Resources Policy 205 designates an external vendor to confidentially receive concerns regarding failure to comply with law, regulation or policy. The vendor will notify AMA of any concern received so that AMA may investigate. HR Policy 205 does not by its terms extend to the House of Delegates, councils, sections, or all other AMA entities, such as the RUC and CPT Editorial Panel.

The Board believes it is preferable to address allegations of harassment at the time they occur, whenever possible. In some cases, individuals who are the recipients of or who witness what they perceive to be harassing conduct may elect to address the conduct with the accused as a first step, giving the individual an opportunity to apologize and to correct behavior. When the recipient or witness is uncomfortable addressing harassing behavior directly, or is dissatisfied with the accused's response to a direct address, the Board recommends that harassing conduct be reported in keeping with the policy set out below.

The Board further believes it is the responsibility of those who chair activities associated with the AMA to assist in enforcing Policy H-140.837, "Anti-Harassment." For meetings of the AMA House of Delegates, the Board deems

the Speaker and Vice Speaker of the House to be appropriate authorities to receive complaints of harassment involving AMA House of Delegates. For other activities associated with the AMA, such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel, the Board deems the presiding officer(s) of such activities to be appropriate authorities to receive complaints. Alternatively, complaints may be lodged with the Chair of the Board or the AMA Office of General Counsel. Absent an emergent situation, the recipient of the complaint must maintain the report in confidence, aside from the further reporting called for by policy. Additionally, and consistent with AMA Human Resources Policy 205, the Board believes that individuals who are not comfortable with in-person reporting to the above-designated authorities should have the option of reporting to an outside vendor.

RECOMMENDATION

Consistent with approaches taken in the professional community and in keeping with existing AMA policy regarding harassment, the Board of Trustees recommends that Policy H-140.837, "Anti-Harassment Policy," be amended by deleting Section 2 thereof, in its entirety, that the following be adopted, and that the remainder of this report be filed:

1. Reporting a complaint of harassment

    Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.

    Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.

    Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.

2. Investigations

    Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. Disciplinary Action

    If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.

    If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality

To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.

REFERENCES

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APPENDIX - AMA Policy H-140.837, "Anti-Harassment Policy"

1. Our AMA adopts the following policy:

Anti-Harassment Policy Applicable to AMA Entities
It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events.

Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

2. Our AMA's Board of Trustees will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident; and consider and prepare for future consideration by the House of Delegates, potential corrective action and/or discipline for conduct in violation of this policy, with report back at the 2017 Interim Meeting.

21. OWNERSHIP OF PATIENT DATA

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2017 Annual Meeting the House of Delegates adopted Policy D-315.976, "Ownership of Patient Data," which asks that our American Medical Association undertake a study on the misuse of patient information by hospitals, corporations, insurance companies, and big pharma, including the impact on patient safety, quality of care, and access to care when a patient's data is withheld from his or her physician.

The testimony on this resolution was unanimously in favor of adoption. Those who spoke discussed the many challenges related to accessing patient data and medical records by physicians, and agreed that a study is needed to better identify these obstacles and begin exploring solutions to the use and misuse of patient information.

This informational report provides an overview of the current laws and regulations at the state and federal levels that address ownership, access and use of patient data including under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations. It also looks at controls and processes in place to address physician and healthcare industry access and use of patient information.

LEGAL AND REGULATORY OVERVIEW

Ownership of, and access to, patient data contained in a medical record are distinct concepts under the law. State laws vary on the topic of who owns a patient's medical record. As depicted in the following graphic from Health Information & the Law[1] the majority of state legislatures either grant ownership of the medical record to the clinician or institution, or remain silent on medical record ownership. New Hampshire uniquely provides that the patient owns the information contained in the medical record.
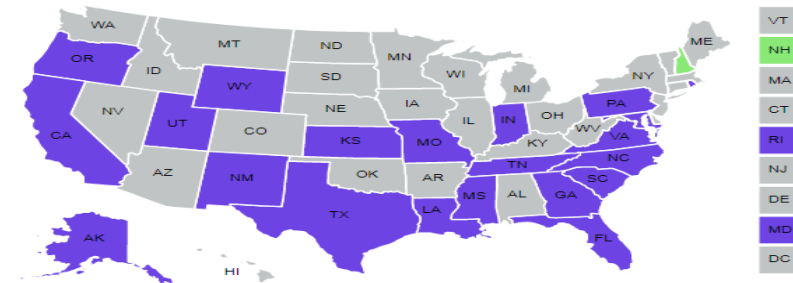
Click on a state to see more information on **Medical Records Collection, Retention, and Access** in that state

Medical Record Ownership Laws
- Hospital and/or physician owns medical record
- Patient owns information in medical record
- No law identified conferring specific ownership or property right to medical record

Ownership of patient data is not specified under HIPAA. Patients, however, have broad access rights to their protected health information (PHI). Patients can also exercise control over whether and how their health information is used and disclosed for certain purposes, including marketing. The following points are highlighted for patients by the U.S. Department of Health & Human Services Office of Civil Rights document titled "Your Health Information Privacy Rights"[2]: (1) Generally, patient health information cannot be used for purposes not directly related to care without permission. For example, a doctor cannot give it to a patient's employer, or share it for things like marketing and advertising, without written patient authorization and (2) patients can ask that their health information not be shared with certain people, groups, or companies.

The Office for Civil Rights (OCR) has an online complaint portal in which anyone can file a complaint against covered entities and their business associates if there is a potential violation of an individual's health information privacy rights or other violation of the Privacy, Security, or Breach Notification Rules. A "Covered Entity" is defined as either a health plan, health care clearinghouse, or health care provider who transmits PHI in electronic form. "Business Associate" is defined in part as a person that provides data transmission services with respect to PHI to a covered entity and that requires access on a routine basis to such PHI. Additionally, a Business Associate may also be a subcontractor that creates, receives, maintains, or transmits PHI on behalf of the business associate. If OCR determines that a covered entity or business associate may have violated the HIPAA Rules, that entity or business associate must either voluntarily comply with the HIPAA Rules, take corrective action, or agree to a settlement with the injured party. Additionally, a civil monetary penalty (CMP) may be imposed on the covered entity if the corrective action is not viewed as satisfactory.

PHYSICIAN ACCESS TO PATIENT RECORDS

Much of the discussion on this resolution centered on the obstacles in accessing patient and medical record data by physicians. This can be a symptom of the physician's contract with the hospital or healthcare entity they are employed by or contracted for services with, or the electronic healthcare record vendor that they or their employer has contracted with.

Contractual Considerations – Employment Agreements

In cases where a physician is an employee of a hospital or other healthcare entity, access to patient and medical record data both during and following employment is often addressed by the employment agreement. The AMA, as well as many state medical societies, provides physicians resources to assist in navigating various issues and ensuring a fair and comprehensive employment agreement. This is especially important during separation.

Depending on its terms, an employment or independent contractor (IC) arrangement between a physician and a hospital or health system should specify who owns the patient records and patient data, and which parties have access rights to the data, including after termination. The parties will negotiate their rights with respect to ownership of and access to the records for specified purposes, including upon patient request.

The "AMA Annotated Model Physician-Hospital Employment Agreement"[3] addresses access to patient records and confidentiality in Section 8.7. While continuity of care is a high priority upon the termination of the contractual employment relationship between a hospital and a physician, equally important is contractual language that acknowledges the physician's entitlement to copies of patient charts and records. "The employer may wish to specify that, upon termination, the physician will not be entitled to keep or copy charts, files, or patient lists;" however, it is common practice to negotiate a provision that allows the physician to obtain the patient records after termination for situations such as a malpractice action, administrative investigation or proceeding against the physician, as they would be necessary to the physician's defense.

AMA Advocacy Efforts and Resources

The AMA model state bill titled "Physician Employment Patient Notification and Records Act" states that, in order to ensure that the termination of their physicians' employment does not disrupt their care; patients must be timely provided with information enabling them to obtain care from alternative physicians or continue to receive care from their physicians post-termination. The model bill also states that access to medical records should be addressed in the employment agreement and should state that the physician is entitled to copies of patient charts and records relating to the physician's provision of physician services: (1) upon written request from the patient, or (2) when records are necessary to address any current or future legal, professional, administrative, regulatory, or other issues, claims, allegations, proceedings, or investigations against, involving or in connection with those services.

The AMA Advocacy Resource Center (ARC) has developed a legislative campaign with the goal of assisting physicians with issues throughout the employment spectrum including negotiating employment contracts, maintaining autonomy during employment, and terminating the relationship.

Federal Regulation and Guidance

The U.S. Department of Health and Human Services (HHS) has also weighed in on the related matter of charging for access to patient or medical records. In March of 2016, OCR issued new guidance[4] including the stipulation that in the case of a request for an electronic copy of PHI maintained electronically, covered entities may charge a flat fee not to exceed $6.50 (inclusive of all labor, supplies, and postage).

Accessing Data through an Electronic Health Record (EHR) Vendor

The second party with which a physician can encounter issues regarding access to patient and medical record data is with their electronic health records vendor. Concerns over ensuring data are readily available to physicians and patients, prompted HHS and the Office of the National Coordinator (ONC) to release a Health IT Playbook[5] to help clinicians navigate the EHR market. HHS and ONC also have developed an EHR contracting guide[6], "EHR Contracts Untangled: Selecting Wisely, Negotiating Terms, and Understanding the Fine Print." The Health IT Playbook and contracting guide are meant to assist clinicians and healthcare institutions in negotiating contract terms with EHR vendors. The publication includes guidance and sample contract terms addressing compliance with HIPAA and the control and access to EHR data - including the avoidance of data blocking.

Contractual Considerations – EHR Vendor Agreement

The use of an EHR contract, including a Business Associate Agreement (BAA), can provide a covered entity, such as a physician, the legal protection necessary to use and disclose patient PHI with a health information exchange (HIE) or third party subcontractor for various purposes. These activities may include health care activities, including but not limited to, claims processing, data analysis, or quality assurance.

Physicians are encouraged to ensure the contract with the EHR vendor clearly defines data rights. Failing to clearly address data access rights in the BAA and any other vendor contract can severely impact the physician's ability to share data with patient registries and HIEs as well as easily transition to a new EHR vendor in the future.

The EHR vendor contract and BAA should also clearly identify what the EHR can and cannot do with the data that is created and used by the physician. The vendor agreement or BAA should address whether or not the vendor is permitted to aggregate de-identified data across different covered entities for medical research, population health management, or other purposes.

AMA Tools and Resources

The AMA's Steps Forward™ module titled "Electronic Records Software Selection and Purchase"[7] provides guidance on negotiating favorable contract terms. The AMA also has model legislation created in response to Policy D-478.972 that required the AMA to develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to HIEs. The bill, titled "An Act to Improve the Transparency of Electronic Health Record Systems Costs and Promote Data Sharing," identifies appropriate disclosures including data sharing capabilities and detailed fees.

Federal Regulations and Guidance

There are cases where it may be challenging to implement this guidance in today's environment. Because of unequal bargaining power and the fact that a hospital or health system, and not an individual physician, often contracts with an EHR vendor, it can be difficult for a physician, practice, or institution to obtain favorable contract provisions. The 21st Century Cures Act (the Act) directs the Secretary of HHS to develop a strategy to reduce EHR regulatory and administrative burdens while placing new requirements upon developers as a condition of certification and maintenance of certification. These requirements address many of the AMA's long-standing concerns with EHRs, including prohibiting vendor data blocking; improving the usability, interoperability, and security of EHRs; and testing certified EHR technology in real-world settings.

The Act provides for penalties of up to $1.0 million per instance for any developers, networks, or exchanges that the Office of Inspector General (OIG) of HHS finds to have committed information blocking.

The AMA has actively provided feedback to ONC, OIG, and HHS on what should and should not be considered blocking and publically, through numerous comment letters, supports the operationalization of the Act's information blocking requirements for health IT vendors. The AMA is expecting the release of the proposed rule around the implementation of the Act's requirements in April of 2018.

USE OF PATIENT RECORDS BY THE HEALTHCARE INDUSTRY

A search on use of EHR records reveals instances where health systems and EHR vendors are entering data agreements to provide de-identified, anonymized data to organizations including medical device manufacturers, technology providers, health information aggregators and clinical researchers. Two recent examples include a partnership between Mercy Health System and Medtronic[8] to share de-identified data from approximately 80,000 patients with heart failure to focus on how patients respond to Cardiac Resynchronization Therapy (CRT). In another recent example Google[9] partnered with academic medical centers to explore how machine learning can be used to mine EHR data for improved outcomes.

EHR vendors also use de-identified patient data gathered through use of their products in population health tools. In a less common scenario, some EHR vendors are providing de-identified, anonymized patient data to health information organizations (HIO) who in turn merge the data with other available datasets and license the combination to government agencies, academia, and businesses for a range of medical research and commercial purposes. This includes pharmaceutical manufacturers who use this information in various aspects of clinical development and commercialization. HIOs also use anonymized patient data to deliver evidenced-based insights about drug safety issues as well as the quality and cost of care.

The search on use of anonymized EHR records also revealed a number of white papers and opinions on the promise of using EHR data for clinical research and improving outcomes stating, however, that there are a number of challenges yet to be overcome to make this effective.

A LOOK FORWARD

A scan of the health technology market shows that data continues to grow in importance. Several companies have announced initiatives and platforms that provide patients access and control of their information. These organizations include a Virginia-based Health IT company, Health Wizz[10], who has created a patient-data platform that allows patients pull their data into the Health Wizz app via EHR patient portals and then use the DirectTrust framework to send their data to providers and other organizations. Apple[11] is giving iPhone users a means to

download their health records from a patient portal, store them safely, and share them with others. The Apple feature, Health Records, is currently in a beta release which includes integration with twelve participating hospital systems. Most recently, CMS Administrator Seema Verma announced the launch of the MyHealthEData Initiative. "MyHealthEData is a government-wide initiative that will break down the barriers that contribute to preventing patients from being able to access and control their medical records. MyHealthEData makes it clear that patients should have access and control to share their data with whomever they want, making the patient the center of our health care system. Patients need to be able to control their information and know that it's secure and private. Having access to their medical information will help them make decisions about their care, and have a better understanding of their health."[12]

AMA POLICY

The AMA has several policies related to this topic (see Appendix). Policy H-315.973, "Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data," which was last updated and reaffirmed in 2013, establishes principles around the use of these data that include compliance with HIPAA, requires physician consent for analysis of the data, and requires data to remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.

In addition, Policy H-315.975, "Police, Payer, and Government Access to Patient Health Information," and Policy H-315.987, "Limiting Access to Medical Records," look to further define who should and should not have access to this information.

Finally, Ethical Opinions E-3.2.4, "Access to Medical Records by Data Collection Companies," E-3.2.1 "Confidentiality", and E-3.3.2, "Confidentiality and Electronic Medical Records," are also relevant to this discussion.

CONCLUSION

This is an issue that will become more complicated as the healthcare industry looks to further connect disparate patient information in an effort to map the patient journey and improve health outcomes. Throughout the progression it is important that patients have appropriate access to their data and physicians have the tools and controls they need to be good stewards of their patients' information while at the same time have the ability to share information to seamlessly coordinate the best care. In support of these initiatives, the AMA has actively engaged with HHS, OIG, and ONC and has broad policy in place covering all aspects of patient record maintenance, access and control.

Physicians and healthcare institutions have the ability to control use and access to the patient data they create within an EHR through agreements with the EHR vendor and business associate agreements. Additionally all PHI contained in the EHR is protected under HIPAA.

Our AMA has taken a leadership role in ensuring appropriate use and access of these data by (1) working with ONC and HHS to encourage operational implementation of provisions in the 21st Century Cures Act to prohibit EHR vendors from blocking access to data and limiting a physician's ability to effectively utilize their EHR system; (2) providing physicians and practices with resources on negotiating employment and independent contractor agreements to assist in clarifying ownership of and access to patient information upon termination of employment or contracting; (3) supplying physicians and practices with educational tools about favorable EHR vendor contract terms covering ownership of, access to, and use of patient information; (4) educating physicians and practices on how to file a HIPAA complaint with the OCR; and (5) providing the Federation of Medicine with model legislation that ensures appropriate handling and access to patient data.

Lastly, technologies are emerging every day that are focused on putting patient data in the patient's hands with the capability of providing access and control to the patient with a mechanism of doing so in a systematic way.

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APPENDIX – AMA Policies Related to this Report

AMA Code of Medical Ethics

Code of Medical Ethics Opinion E-3.2.4, "Access to Medical Records by Data Collection Companies"
Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality.
Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment recommendations, such as pharmaceutical or medical device companies.
Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.
Physicians who propose to permit third-party access to specific patient information for commercial purposes should:
(a) Only provide data that has been de-identified.
(b) Fully inform each patient whose record would be involved (or the patient's authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.
Physicians who propose to permit third parties to access the patient's full medical record should:
(a) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.
(b) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.
(c) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.

Code of Medical Ethics Opinion E-3.3.1, "Management of Medical Records"
Physicians have an ethical obligation to manage medical records appropriately.
Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.
In keeping with the professional responsibility to safeguard the confidentiality of patients' personal information, physicians have an ethical obligation to manage medical records appropriately.
This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.
To manage medical records responsibly, physicians (or the individual responsible for the practice's medical records) should:
(a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients' medical records by unauthorized staff.
(b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including: 1. Immunization records, which should be kept indefinitely; 2. Records of significant health events or conditions and interventions that could be expected to have a bearing on the patient's future health care needs, such as records of chemotherapy
(c) Make the medical record available: 1. As requested or authorized by the patient (or the patient's authorized representative) 2. To the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death) 3. As otherwise required by law
(d) Never refuse to transfer the record on request by the patient or the patient's authorized representative, for any reason.
(e) Charge a reasonable fee (if any) for the cost of transferring the record.
(f) Appropriately store records not transferred to the patient's current physician.

(g) Notify the patient about how to access the stored record and for how long the record will be available.
(h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

Code of Medical Ethics Opinion 3.3.2, "Confidentiality and Electronic Medical Records"
Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.
Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:
(a) Choose a system that conforms to acceptable industry practices and standards with respect to: 1. Restriction of data entry and access to authorized personnel 2. Capacity to routinely monitor/audit access to records 3. Measures to ensure data security and integrity 4. Policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance
(b) Describe how the confidentiality and integrity of information is protected if the patient requests.
(c) Release patient information only in keeping with ethics guidance for confidentiality.

Code of Medical Ethics Opinion 3.2.1, "Confidentiality"
Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.
In keeping with the professional responsibility to safeguard the confidentiality of patients' personal information, physicians have an ethical obligation to manage medical records appropriately.
This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.
To manage medical records responsibly, physicians (or the individual responsible for the practice's medical records) should:
(a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients' medical records by unauthorized staff.
(b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including: 1. Immunization records, which should be kept indefinitely 2. Records of significant health events or conditions and interventions that could be expected to have a bearing on the patient's future health care needs, such as records of chemotherapy
(c) Make the medical record available: 1. As requested or authorized by the patient (or the patient's authorized representative) 2. To the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death) 3. As otherwise required by law
(d) Never refuse to transfer the record on request by the patient or the patient's authorized representative, for any reason.
(e) Charge a reasonable fee (if any) for the cost of transferring the record.
(f) Appropriately store records not transferred to the patient's current physician.
(g) Notify the patient about how to access the stored record and for how long the record will be available.
(h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

AMA Policy

H-315.973, "Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data"
1.   It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:
a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.
b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.
c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.
d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.
e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.
f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.
g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.
h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.
2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:

a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.
b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.
c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.
d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.

H-315.987, "Limiting Access to Medical Records"
Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills.

H-315.975, "Police, Payer, and Government Access to Patient Health Information"
(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.
(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.
(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.
(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.
(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

H-315.979, "Electronic Data Interchange Status Report"
Our AMA will: (1) work to establish consensus on industry security guidelines for electronic storage and transmission of medical records as an important means of protecting patient privacy in a manner that avoids undue and non-productive burdens on physician practices; and (2) develop relevant educational tools or models in accordance with industry electronic security guidelines to assist physicians in compliance with state and federal regulations.

H-155.994, "Sharing of Diagnostic Findings"
The AMA (1) urges all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records, including histories and diagnostic procedures, so that the hospital physicians sharing in the care of those patients can practice more cost-effective and better medical care; (2) urges the hospital to return all information on in-hospital care to the attending physician upon patient discharge; and (3) encourages providers, working at the local level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures.

H-315.977, "Abuse of the Medical Record for Regulation or Financing the Practice of Medicine"
1) Our AMA continues to oppose the use of the physician office medical record as a tool of CMS, as well as any other agency or third party, to regulate the financing and practice of medicine. (2) The medical record shall be the property of the physician and the information contained therein, the property of the patient. (3) The physician's office medical record should be used solely to document the delivery of health care.

H-315.971, "Patient Information in the Electronic Medical Record"
AMA Guidelines for Patient Access to Physicians' Electronic Medical Record Systems:
(1) Online interactions are best conducted over a secure network, with provisions for privacy and security, including encryption.
(2) Physicians should take reasonable steps to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it. Physicians are encouraged to follow the following guidelines for patient authentication: (a) Have a written patient authentication protocol for all practice personnel and require all members of the physician's staff to understand and adhere to the protocol. (b) Establish minimum standards for patient authentication when a patient is new to a practice or not well known. (c) Keep a written record, electronic or paper, of each patient authenticated.
(3) Prior to granting a patient access to his or her EMR, informed consent should be obtained regarding the appropriate use of and limitations to access of personal health information contained in the EMR. Physicians should develop and adhere to specific guidelines and protocols for online communications and/or patient access to the EMR for all patients, and make these guidelines known to the patient as part of the informed consent process. Such guidelines should specify mechanisms for emergency access to the EMR and protection for and limitation of access to, highly sensitive medical information.
(4) If the patient is allowed to make annotations to his or her EMR (i.e., over-the-counter drug treatments, family medical history, other health information), the annotation should be indicated as authored by the patient with sourcing information (i.e., date and time stamp, login and IP address if applicable). A permanent record of all allowed annotations and communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.
(5) Physicians retain the right to determine which information they do and/or do not import from a PHR into their EHR/EMR and to set parameters based on the clinical relevance of data contained within personal health records.
(6) Any data imported into a physician's EMR/EHR from a patient's personal health record (PHR) must preserve the source information of the original data and be further identified as to the PHR from which it was imported as additional source information to preserve an accurate audit trail.
(7) In order to maintain the legitimate recording of clinical events, patients should not be able to delete any health information in the record. Rather, in order to maintain the forensic nature of the record, patients should only be able to add notations when appropriate.
(8) Disclosures of Personal Health Information should comply with all applicable federal and state laws, privileges recognized in federal or state law, including common law, and the ethical requirements of physicians.

D-478.972, "EHR Interoperability"
Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.

22. IN-FLIGHT EMERGENCIES
(RESOLUTION 516-A-17, RESOLVE 3)

Reference committee hearing: see report of Reference Committee E.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
                    IN LIEU OF RESOLUTION 516-A-17, RESOLVE 3
                    REMAINDER OF REPORT FILED**
                    See Policy H-45.979

INTRODUCTION

At the AMA House of Delegates 2017 Annual Meeting, Resolve 3 of Resolution 516-A-17, "In-Flight Emergencies," introduced by the Minority Affairs Section and referred by the House of Delegates (HOD), asked:

> That our American Medical Association (AMA) support and advocate for a requirement that fight crews will no longer be required to verify a medical professional's credentials before allowing that person to assist with an inflight medical emergency (IFME).

The original resolution explains that in instances of heart failure a lack of oxygen can cause brain damage in only a few minutes. "A person may die within 8 to 10 minutes and may experience cognitive deficits if deprived of oxygen

for greater than 4 minutes." Thus, the extra time it would take for flight staff to verify credentials of a passenger offering to render emergency medical assistance during an IFME could lead to a negative patient outcome.

This report will outline the current requirements concerning the verification of a medical professional's credentials in the event of an IFME and existing AMA policies on physician identification of credentials and delivery of health care by Good Samaritans.

BACKGROUND

The Aviation Medical Assistance Act of 1998

Currently there is no federal law mandating that air carriers verify medical credentials or identification before allowing medical professionals to assist in emergency situations. - The law only requires that air carriers believe in good faith that an emergency volunteer is medically qualified, in order to not be liable for damages arising out of the acts or omissions of the passenger (e.g., a physician passenger) rendering assistance of a passenger during an IFME. In relevant part, the Aviation Medial Assistance Act of 1998 states that:

> SECTION 5. LIMITATIONS ON LIABILITY. (a) Liability of Air Carriers.--An air carrier shall not be liable for damages in any action brought in a Federal or State court arising out of the performance of the air carrier in obtaining or attempting to obtain the assistance of a passenger in an in-flight medical emergency, or out of the acts or omissions of the passenger rendering the assistance, if the passenger is not an employee or agent of the carrier and the carrier in good faith believes that the passenger is a medically qualified individual.

Online Forum

A comment on Resolution 516 was provided by a physician on the online forum. The commenting physician expressed opposition to the resolution for a number of reasons. First, he drew from personal experience and explained that a customary procedure already exists for a physician to come forth with the appropriate medical documents before treating an individual. Next, he explained that there are enough examples of individuals who attempt to act as a physician without credentials to justify having a flight crew member verify identification in order to protect patients. He also explained that credentialing should not be taken lightly. Lastly, he highlighted that most commercial flights today have Wi-Fi capability and crews can easy and quickly check credentials with state medical boards online. Note, the commenting physician interprets the requirement for verification of a physician's credentials as requiring either physical identification or by validation through an online credential inquiry. As noted above, the law only requires good faith belief by an air carrier that the passenger who volunteers to render assistance during an IFME is a medically qualified individual. In practice, this could mean viewing physical identification or online credentials or, could be achieved by requiring only a verbal statement by such passenger concerning his or her credentials before allowing the passenger to provide assistance during an IFME.

Relevant Current AMA Policy

Extensive AMA policies address IFMEs. Current AMA Policy H-45.997, "In-Flight Emergency Care," supports legislative provisions that grant any physician, other medical professional, or airline employee, acting in the role of a Good Samaritan during an in-flight medical emergency, an umbrella of immunity against legal or personal redress by the airline, the passengers, or the persons involved in the medical emergency. Policy H-45.978, "In-Flight Medical Emergencies," discusses in-flight emergency medical supplies and equipment and implementation of comprehensive in-flight emergency medical systems that ensure direct supervision by physicians with appropriate training in emergency and aerospace medicine. Policy H-45.979, "Air Travel Safety," encourages actions to support education of physicians on available options if asked to render assistance during an IFME to encourage full and effective participation when an IFME occurs.

In addition, there are existing AMA policies that address physician identification generally and during emergencies specifically. Policy H-405.987, "Identification of Board Certified Physicians," urges physicians to identify themselves by stating the full name of their certifying board. Note, Policy H-405.987 only requires a verbal statement of credentials. Policy H-130.937, "Delivery of Health Care by Good Samaritans," describes basic guidelines to apply in instances where a physician happens upon the scene of an emergency and desires to assist and render medical assistance. Policy H-130.937 states, in part that it is the obligation of the bystander physician to

provide reasonable self-identification. This policy refers to situations in which a bystander physician, parallel to an in-flight emergency physician, volunteers to provide emergency aid in collaboration with EMS providers. While flight crews are not EMS providers or medical experts this policy is instructive. Similar to the EMS team and physician, an in-flight physician and flight crew may have to "work collaboratively" in assessing the medical emergency and providing reasonable self-identification is appropriate. Note Policy H-130.937 only requires verbal or hand signal verification of self-identification, not verification via physical identification or an online credential inquiry.

CONCLUSION

Based on existing federal law (which does not require verification of medical credentials during an IFME), AMA policies described in this report, and industry guidelines on the topic of IFMEs and physician identification during medical emergencies, the Board of Trustees believes further efforts on this topic by our AMA are not necessary. It is reasonable for air carriers to determine the level and manner of verification of medical credentials (which could be achieved by a verbal statement) to establish a good faith belief that the passenger is a medically qualified individual before allowing a passenger to provide assistance during an IFME. This position would be consistent with existing AMA policies.

RECOMMENDATION

The Board of Trustees recommends existing AMA Policy H-45.979, "Air Travel Safety," be reaffirmed in lieu of Resolve 3, Resolution 516-A-17, and the remainder of the report be filed.

AMA Policy

H-45.978, "In-Flight Medical Emergencies"
Our AMA urges: (1) urges that decisions to expand the contents of in-flight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; in-flight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure:

(a) rapid 24-hour access to qualified emergency medical personnel on the ground;
(b) at a minimum, voice communication with qualified ground-based emergency personnel;
(c) written protocols, guidelines, algorithms, and procedures for responding to in-flight medical emergencies;
(d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form;
(e) adequate medical supplies and equipment aboard aircraft;
(f) routine flight crew safety training;
(g) periodic assessment of system quality and effectiveness; and
(h) direct supervision by physicians with appropriate training in emergency and aerospace medicine.

H-45.979, "Air Travel Safety"
Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and (3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar.

H-130.937, "Delivery of Health Care by Good Samaritans"
1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
2. Our AMA encourages state medical societies in states without "Good Samaritan laws," which protect qualified medical personnel, to develop and support such legislation.
3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of

medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.

4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.

23. HEALTH CARE AS A HUMAN RIGHT
(RESOLUTION 7-A-17)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED**
                     IN LIEU OF RESOLUTION 7-A-17
                     REMAINDER OF REPORT FILED
                     See Policies H-160.975, H-160.987, H-250.986, H-250.992 and H 250.999

INTRODUCTION

At the 2017 Annual Meeting, the House of Delegates referred Resolution 7-A-17, "Health Care as a Human Right." This resolution was introduced by the Minority Affairs Section and asked that our AMA:

1.   recognize that a basic level of health care is a fundamental human right;

2.   support the United Nations' Universal Declaration of Human Rights and its encompassing International Bill of Rights as guiding principles fundamental to the betterment of public health; and

3.   advocate for the United States to remain a member of the World Health Organization.

HEALTH CARE AS A HUMAN RIGHT

Human rights are ethical demands that create duty to safeguard underlying freedoms of significant social importance.[1] This duty may be legal, e.g., through statute or international treaty, or moral in its foundation. Depending on context, human rights can be thought of as legal, philosophical, or sometimes aspirational.[2] All these concepts of human rights are interrelated; indeed, human rights are conceived through ethical reasoning drawing on experience, beliefs, and theories of justice.

The philosophical underpinning of creating an ethical human right is largely that of justice, which may be described as fairness in equitable distribution of primary social goods[3] such as liberty, opportunity, and income. From this concept of fairness comes the ethical demand to create a human right, which may then be extended to health care, because by keeping people healthy, people's ability to participate in political, social, and economic life is promoted and preserved.[4] A right to health care does not give individuals a basic right either to be healthy or to have all their health care needs met.

However, a right to health care will broadly encompass access to care.[5] Access means that health care facilities, goods, and services must be available to everyone in [a defined] jurisdiction without discrimination, [and must be]

affordable, physically accessible, and within a reasonable distance for all people.[6] If people are denied access to a basic level of services adequate to protect normal functioning, an injustice is done to them. Indeed, the concept of accessibility as a core principle of human rights to health care is widely recognized and supported.

AMA Policy

Although it does not directly support a "right to health care," Principle IX of the AMA Principles of Medical Ethics states: "A physician shall support access to medical care for all people." Equitable access to medical care is a core component of the right to health care, and Opinion 11.1.1, of the *Code of Medical Ethics*, "Defining Basic Health Care," is derived from this principle. The Opinion maintains that health care is "a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. Society has an obligation to make access to an adequate level of care available to all its members, regardless of ability to pay." Further, Opinion 11.1.4, "Financial Barriers to Health Care Access," explains: "As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means."

Other policies of the AMA House of Delegates also support access to healthcare. For example, it is AMA policy that "no one shall be denied necessary medical care because of inability to pay for that care" (Policy H-160.987, "Access to Medical Care"). Policy H-160.975, "Planning and Delivery of Health Care Services," explains that "both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing shortcomings in the current public system for providing access need to be addressed."

SUPPORTING THE UNITED NATIONS' DECLARATION OF HUMAN RIGHTS AND THE WORLD HEALTH ORGANIZATION

Resolution 7-A-17 also asks that our AMA support the United Nations' Universal Declaration of Human Rights and the International Bill of Rights as guiding principles fundamental to the betterment of public health. The Declaration consists of 30 articles affirming an individual's rights that, although not legally binding in themselves, have been elaborated in subsequent international treaties, economic transfers, regional human rights instruments, national constitutions, and other laws. The Declaration was the first step in the process of formulating the International Bill of Human Rights, which was completed in 1966, and came into force in 1976.

The United Nations (UN) is an intergovernmental organization made up of 193 member nations. The World Health Organization (WHO) is the directing and coordinating authority on international health within the UN system. The objective of WHO is the attainment by all peoples of the highest possible level of health. Governance takes place through the World Health Assembly (WHA), which is made up of representatives from the health ministries of these national governments, and is the supreme decision-making body. The Executive Board gives effect to the decisions and policies of the Health Assembly. The organization is headed by the Director-General, who is appointed by the WHA on the nomination of the Executive Board. The WHO collaborates with the UN system to position health in the debates and decisions of UN intergovernmental bodies; contributes to a coherent and effective UN system at global, regional, and country levels; provides leadership in health-related humanitarian efforts, and promotes alliances and interagency approaches to address health issues.

By contrast, the WMA is a non-governmental international organization representing physicians. The organization was created to ensure the independence of physicians and to work for the highest possible standards of ethical behavior and care by physicians at all times. The AMA is a founding member of the WMA, which has always been an independent confederation of free professional associations and has grown to include 114 national medical association members. Our main role at the WMA is to develop policy and advocacy agendas in line with AMA policies.

The WMA is in "Official Relations" with the WHO and seeks to advise and influence the work of this intergovernmental body. WMA's cooperation with the WHO is very broad and covers nearly all areas of medicine and health. As a commitment to our international interests, AMA officers have regularly attended the WHA, either as non-governmental advisors to the United States Delegation or as Delegates to the Assembly from the WMA.

AMA Policy H-250.986, "AMA and Public Health in Developing Countries," outlines a circumscribed strategy for AMA participation in international policy and advocacy issues mainly by our involvement in the WMA and, to a lesser degree, in our advisory capacity at the WHA. For this and other reasons, our AMA does not take positions on treaties, such as the United Nations' Universal Declaration of Human Rights, but works through established channels to effect supportable outcomes.

In addition, AMA Policy H-250.999, "World Health Organization," expresses AMA's direct support of the WHO as an institution and the United States' involvement with it; this support is ongoing. AMA Policy H-250.992, "World Health Organization," affirms support for the WHO and urges the United States to provide full funding for the organization. This policy also encourages the WMA to develop cooperative work plans with the WHO.

CONCLUSION

The Board of Trustees appreciates that Resolution 7-A-17 expresses the desire to ensure that all people have access to a basic level of health care. Our AMA has long advocated for equitable access to health care through policy, advocacy, and a targeted strategy of active international policymaking through the WMA and the WHO. The Board of Trustees believes that existing policy adequately supports that intention.

RECOMMENDATION

The Board of Trustees therefore recommends that AMA Policies H-160.987, "Access to Medical Care;" H-160.975, "Planning and Delivery of Health Care Services;" H-250.986, "AMA and Public Health in Developing Countries;" H-250.992, "World Health Organization;" and H-250.999, "World Health Organization," be reaffirmed in lieu of Resolution 7-A-17 and that the remainder of the report be filed.

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24. APPROPRIATE PLACEMENT OF TRANSGENDER PRISONERS (RESOLUTION 15-A-17)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
**   IN LIEU OF RESOLUTION 15-A-17**
**   REMAINDER OF REPORT FILED**
                   See Policy H-430.982

At the 2017 Annual Meeting the AMA House of Delegates referred Resolution 15-A-17, "Appropriate Placement of Transgender Prisoners," from the New England delegation, which asked:

That our American Medical Association establish policy supporting the ability of transgender prisoners to be placed in facilities that are reflective of their affirmed gender status regardless of surgical status, if they so choose.

The Reference Committee on Amendments to Constitution and Bylaws noted that testimony was evenly divided in support of the resolution and ultimately recommended referral, recognizing the "complexities of this issue" and "that

more information and research on the subject are necessary." In response, this report identifies and addresses concerns relevant to the placement of transgender prisoners.

BACKGROUND

The problem facing the safety and health of transgender prisoners is severe and well documented. Transgender prisoners are disproportionately the victims of sexual assault, suffering higher rates of sexual assault than general population inmates [1,2]. The increased rate of violence largely stems from transgender prisoners being housed based on their birth sex, and not according to their affirmed gender [1]. One study showed that birth sex-based housing policy has allowed transgender prisoners to suffer from rape, harassment, and physical violence at a rate of 34 percent compared to 10 percent for the overall population [3]. Another study, of only California prisons, has shown that 59 percent of transgender prisoners experience sexual assault, versus only 4.4 percent of the overall prison population [4], with another study showing that the proportion of transgender prisoners in California experiencing sexual assault to be as high as 75 percent [1].

The risks of violence typically are in the context of transfeminine inmates, because "of animosity toward the expression of their gender identity and because many have slight and effeminate builds" [5]. Genitalia-based prison housing policies place transgender inmates at special risk of sexual violence, because the "prison hierarchy subjugates the weak to the strong and equates femininity with weakness" [6].

GENITALIA/BIRTH SEX-BASED HOUSING POLICY

The status quo of most prisons and jails in the United States is to house transgender prisoners according to their birth/biological sex and not according to their affirmed gender identity [7]. Genitalia based housing policy is "deeply ingrained" in the United States to the point where it is taken for granted without any official justification [8]. This status quo is founded on a limited definition of "transgender" constrained to the "gender binary," a social construct where only two genders are recognized at birth: male or female [7,9]. A more useful definition of "transgender," one that breaks free of the "gender binary," is a person "whose inner gender identity and outward gender expression differ from the physical characteristics of the body at birth" [10].

Under the status quo, many correctional institutions try to ameliorate the risks and hazards of sex-based housing by placing transgender prisoners in administrative segregation. Such segregation, in the interests of safety, isolates transgender prisoners from the general population [1]. However, administrative segregation is not a good solution as it creates its own sets of problems. It often differs little from punitive segregation or solitary confinement. Such confinement removes prisoners from the companionship of others, denies prisoners access to prison programs, and is psychologically damaging [7]. Administrative segregation acts as a further punishment of the transgender prisoner and has been significantly criticized by scholars and attorneys [2].

ALTERNATIVE HOUSING POLICIES

In an attempt to address health and safety problems of transgender prisoners several jurisdictions have created alternative jail housing policies based on "the sex the individual identifies with and where they will be the safest, as opposed to genitalia-based placement" [9].

For example, in 2002 San Francisco County, California, instituted a protocol that requires jail officials to assess transgender prisoners for vulnerability and place vulnerable individuals in a unit with other vulnerable populations, away from "predators;" the policy has resulted in marked decreases in sexual assaults [2]. In 2009 the Washington, DC, Department of Corrections similarly enacted a housing policy that takes into account the opinions of transgender individuals and healthcare professionals and permits inmates to be housed according to their gender identity [9,11]. In 2011 Cook County, Illinois, likewise changed its policy to allow transgender inmates to "be housed, dressed, and searched according to their gender identity rather than the sex/gender they were assigned at birth" [9].

AMA POLICY

Several AMA policies address a range of transgender issues [12,13,14]. House Policy H-65.964, "Access to Basic Human Services for Transgender Individuals," opposes policies that prevent transgender individuals from accessing

services and facilities (including restrooms) in line with one's gender identity [12]. House Policy H-65.967, "Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients," supports policies that allow for a change of sex designation on a birth certificate for transgender individuals, whether or not an individual has undergone surgery [13]. House Policy H-40.966, "Military Medical Policies Affecting Transgender Individuals," affirms that there is no medical reason to prohibit transgender individuals from serving in the military [14].

RECOMMENDATION

In consideration of evidence indicating the risk placement choices pose for transgender prisoners the Board of Trustees recommends that the following be adopted in lieu of Resolution 15-A-17 and the remainder of this report be filed:

1. That our American Medical Association supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status; and

2. That our American Medical Association supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

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25. RECOGNITION OF PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) FORMS (RESOLUTION 20-A-17)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED AS FOLLOWS**
IN LIEU OF RESOLUTION 20-A-17
REMAINDER OF REPORT FILED
See Policy D-85.992

At the 2017 Annual Meeting, the House of Delegates referred Resolution 20-A-17, "Recognition of Physician Orders for Life Sustaining Treatment (POLST) Forms," introduced by the Organized Medical Staff Section, which asked:

> That our American Medical Association advocate with appropriate government, legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment forms completed in one state as valid and enforceable in other states; and

> That our AMA create a universal Physician Orders for Life Sustaining Treatment form that would be valid and enforceable in all states.

The reference committee heard testimony unanimously in support of the intent of the resolution. Testimony highlighted the challenges of respecting the medical care orders of patients when they cross jurisdictional boundaries. However, testimony also emphasized that a universal POLST form may be impractical because POLST is one of many end-of-life care frameworks in use in the United States.

The reference committee agreed that reciprocity of physician orders between states is important, but noted myriad problems with a universal POLST form. The Reference Committee suggested that "model state legislation be crafted in order for [reciprocity] to be accomplished in a way that can realistically be implemented" and referred the resolution. This Board Report provides background and discussion of interstate recognition of POLST and provides a recommendation.

BACKGROUND

Physician Orders for Life Sustaining Treatment were created in the 1990s in the state of Oregon in response to concerns that Do Not Resuscitate Orders (DNRO) had certain inadequacies; chief among them was their inability to transfer to other facilities (nursing homes, hospitals, hospice, ER's, etc.) as the patient moved [1,2]. POLST was created to improve "end-of-life care by overcoming many of the advance directives' limitations. It is designed to convert patient preferences for life-sustaining treatment into immediately actionable medical orders" that then "can be followed by medical personnel regardless of the patient's location" [3,4]. POLST has largely been successful, with studies showing greater effectiveness in care "delivered in accordance with patient wishes" and recent years have seen increased adoption of the program in states around the country [5]. POLST is increasingly becoming established, alongside advance directives, as an important end-of-life decision making tool.

However, a problem has emerged with the recognition of POLST as patients cross state lines. There is a lack of uniformity in how states recognize a POLST from other states. This creates uncertainly if a POLST originating in one state will be followed in another state. This uncertainty risks the proper adherence of a patient's desires regarding life-sustaining treatment as they travel from one state to another.

STATE LAW

To be effective, a POLST program must be universally recognized and honored. While POLST in each state aims to achieve the same goal of honoring patient wishes during a medical crisis, each state has its own requirements and procedures for a valid POLST.

POLST currently exists at some level in all 50 states and Washington, DC. Sixteen states explicitly recognize out-of-state POLST: Colorado, Delaware, the District of Columbia, Georgia, Idaho, Illinois, Iowa, Maryland, Nevada, New Jersey, New York, Oregon, Rhode Island, Utah, Vermont and West Virginia. Only one state expressly limits reciprocity. In Oklahoma, an out-of-state form is only valid for 10 days after patient's admission into an Oklahoma medical facility [6]. In states with statutes that are silent on reciprocity, accepted medical practice or custom may allow recognition of an out-of-state POLST absent statutory guidance.

There are four main statutory approaches taken to POLST reciprocity: states may honor a POLST if it complies with the originating state's requirements, if it complies with the receiving state's requirements, if it reasonably satisfies the receiving state's requirements or if it complies with either the originating or receiving state's requirements. State laws vary on approach [7].

ETHICAL ISSUES

The scope of Resolution 20-A-17 is focused on the portability of POLST across state lines. In this context, significantly relevant is the ethical force of autonomy in end-of-life decision making and how it is central to continual support of POLST. "The POLST process increases the likelihood that each person will receive the desired care and not receive undesired care" [2]. Indeed, studies have also shown POLST to be successful in the "honoring of patient preferences" [8]. The fundamental ethical principle of patient autonomy (the driving force behind POLST) is the reason why, despite ethical shortcomings that exist with any end-of-life decision making model, POLST remains a durable clinical decision making tool. Therefore, there is ethical impetus to see greater portability of POLST across states lines, as the more likely a POLST from one state is enforced and recognized by another state, the greater likelihood that a patient's autonomy at the end-of-life will be respected.

RELEVANT AMA POLICIES

End-of-life decision making is a significant issue in the medical profession and in the field of bioethics. As such, the AMA is strongly supportive of the concept and has published its support for such measures. For example, Chapter 5 of the Code of Medical Ethics focuses on caring for patients at the end of life. This chapter of the Code has several opinions supporting the concept of advance care planning and withholding life-sustaining treatment [9,10,11,12]. The Code explains that "advance care planning is widely recognized as a way to support patient self-determination" and that a patient "has the right to decline any medical intervention or ask that an intervention be stopped, even when that decision is expected to lead to his or her death" [9,11].

The AMA has additionally shown its support for end-of-life decision making through numerous House Policies and Directives [13,14,15,16,17,18]. Policies have called for the AMA to encourage people to establish advance directives and explain that advance directives "are the best insurance for individuals that their interests will be promoted in the event they become incompetent" [13,14]. Also, the AMA has adopted a directive to endorse "The Uniform Health-Care Decisions Act," a uniform law designed to help govern, simplify, and standardize advance directives [18]. AMA policy does not address issues of reciprocity across jurisdictions.

DISCUSSION

Resolution 20-A-17 would instruct the AMA to create a universal POLST form. Drafting a universal POLST form is fraught with challenges as different jurisdictions have different hierarchies, rules and statutes with regards to end-of-life care. A universal form will not work across all states, as some states may not be able to adopt such a form.

The reference committee's recommendation to create model legislation that would enable POLST reciprocity between the states is a more workable solution. This approach was recognized by the National POLST Paradigm Task Force (NPPTF) legislative group. The group, an assembly of health law experts tasked with providing perspectives to POLST legal issues, offered solutions, among other things, to the problem of POLST portability across state lines. The group recommended the adoption of a "uniform law" that would offer reciprocity of POLST across state lines. The NPPTF legislative group notes:

> While it is still under revision and not directly applicable to POLST, one potential source of guidance is the draft Inter-jurisdictional Recognition of Substitute Decision-Making Documents Act from the National Conference of Commissioners on Uniform States Laws [19]. If adapted to POLST, the reciprocity provisions in

this Act would deem a POLST form valid if, when completed, it complied with the law of the jurisdiction where it was completed [7].

However, a uniform law from the National Conference of Commissioners on Uniform State Laws specifically with regards to POLST is not yet in existence and remains a theoretical solution to the problem of POLST portability. Until such uniform law is available for consideration, states may elect to enact legislation establishing reciprocity to address current problems with POLST compliance across jurisdictions.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 20-A-17, and that the remainder of this report be filed:

1. That our American Medical Association work with state medical associations to advocate with appropriate legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment (POLST) forms completed in one state as a expression of a patient's directions for care; and

2. That our AMA draft model state legislation and guidelines that will allow for reciprocity and / or recognition of POLST and other patient decision-making forms.

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26. REVISION OF RESEARCHER CERTIFICATION AND INSTITUTIONAL REVIEW BOARD (IRB) PROTOCOLS (RESOLUTION 11-A-17)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED**
                                 IN LIEU OF RESOLUTION 11-A-17
                                 REMAINDER OF REPORT FILED
                                 See Policy H-460.892

Resolution 11-A-17, "Revision of Researcher Certification and Institutional Review Board (IRB) Protocols," sponsored by the Florida Delegation, was referred by the House of Delegates in June 2017. This resolution asks our AMA to:

[S]tudy existing Collaborative Institutional Training Initiative standards, Institutional Review Board protocols and create recommendations that would simultaneously protect patients and permit physicians to easily participate in the dissemination of medical knowledge.

HUMAN SUBJECTS PROTECTIONS

Concerns about the ethical conduct of research involving human participants date back to the 19th century, well before the evolution of the current regulatory framework in the U.S. [1]. The principles underlying the current system of oversight of human subjects protections were set out in the 1979 *Belmont Report* by the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research [2], and subsequently codified in regulations adopted by the Department of Health and Human Services (DHHS) and by 14 departments and agencies a decade later—the "Common Rule" [3]. The Common Rule sets basic standards for research oversight, including the establishment of institutional review boards (IRBs) and review procedures, and criteria for individual informed consent [4]. The goal of this—and similar regulatory efforts in other countries—is to protect the rights and well-being of individuals who participate as subjects in biomedical and behavioral research.

The Common Rule has been criticized as ineffective, cumbersome, and of questionable value in actually protecting research participants [5-7]. A 2011 review of empirical studies indicated, for example, that there is considerable variation in IRB structure, membership, processes, and in outcomes of IRB reviews [6]. A recent study of whether and how essential elements of human subjects protection are implemented during institutional review or research protocols found considerable variation among 20 participating IRBs [8]. The current system of oversight has also been critiqued as unable to address effectively the challenges of today's research landscape, especially in light of the increasing prominence of multi-site research involving large numbers of participants and research involving large data sets or collections of biospecimens, and their implications for informed consent [9].

In 2011, the DHHS launched a review and reassessment of the Common Rule, issuing an Advanced Notice of Proposed Rule Making (ANPRM) seeking public comment to enhance protection of research subjects and improve the process of research review [10].

Four years later, DHHS issued a Notice of Proposed Rule Making (NPRM) soliciting comment on proposed updated policy. Stakeholders opposed the NPRM's proposal to require consent for secondary research use of unidentified biospecimens, but supported proposals for improving informed consent, especially for simplifying consent forms while suggesting some modifications, which are reflected in the Final Rule issued in January 2017 [11-12]. The Final Rule also retains provisions intended to reduce unnecessary regulation and streamline oversight processes, including creating new categories of exemption from IRB review for low-risk studies, eliminating the requirement of continuing review for some categories of research, and introducing new options for facilitating screening of prospective participants. (On January 19, 2018, DHHS issued notice that it would delay the compliance deadline for the updated Common Rule to July 19, 2018 [13].)

In 2008 and 2009, AMA shared its concern that over interpretation of Common Rule protections in the context of quality improvement activities imposed unnecessary regulatory burdens on important research [14-16]. AMA also provided input under the auspices of the Advanced Notice of Proposed Rule Making [17] and the Notice of Proposed Rule Making [18].

EDUCATING THE RESEARCH COMMUNITY ABOUT HUMAN SUBJECTS PROTECTIONS

The National Institutes of Health requires that "key personnel" on NIH-funded research involving human subjects receive education on protecting human subjects [19]. These include principal investigators and all other individuals who are responsible for the design or conduct of the research, including foreign awardees or foreign subcontractors and third party personnel or consultants, even if they are not compensated through the NIH award, as well as investigators involved in research that is exempt from IRB review. Investigators in research with human specimens, tissues, or data that has been determined not to involve human subjects in keeping with guidance from the Office for Human Research Protections (OHRP) are not required to fulfill the educational requirement, nor are personnel who are not involved in the design and conduct of human subject research. NIH leaves the decision of what educational programs to use to meet this requirement to investigators' home institutions. The NIH Clinical Center offers free online education that institutions may elect to meet the education requirement.

In addition, the Collaborative Institutional Training Initiative (CITI) offers web-based education in human subjects protections developed by experts in research ethics, ethics committee process, and web-enabled learning [20-21]. Initially created in 2000 in response to the then newly announced NIH education requirement for agency grantees, CITI's offerings have expanded over time to encompass a robust catalogue of instruction in multiple aspects of the responsible conduct of research. Modules are available to learners through institutional subscriptions (at a current cost of $3,400/year) or for purchase by individuals ("independent learners") (currently $130/module).

Training is also available specifically for IRB members. OHRP, for example, offers periodic workshops on various topics in human subjects protections and has developed extensive policy guidance. It also offers practical tools to clarify interpretation of the Common Rule and help IRBs evaluate research protocols effectively; for example, decision charts to help IRBs answer such key questions as whether a proposed study involves human subjects, whether it is exempt from IRB review (or eligible for expedited review), or whether informed consent may be waived. Educational resources for IRBs are also available through organizations such as Public Responsibility in Medicine and Research (PRiMR), which offers certification for IRB professionals [5].

Although there are reservations about their effectiveness in meaningfully protecting human subjects, efforts have also been launched to accredit IRBs.[5] Thus the Association for the Accreditation of Human Research Protection Programs (AAHRPP) promotes quality standards and performance improvement for IRBs and institutional human research protection programs [6].

INSTITUTIONAL AND JOURNAL POLICIES

Institutions that carry out federally funded research, as well as professional journals that publish the findings of research with human subjects have similarly established expectations that research personnel will adhere to human subjects protections in keeping with federal regulations. For example, the University of Illinois at Champaign Urbana requires that researchers complete CITI's "Core Basic Training for either social/behavioral research or biomedical research," and more specialized modules as may be needed for the purposes of specific studies, such as those involving children [22]. The University of California-Berkeley likewise requires that faculty, students, and staff engaged in human subjects research complete appropriate CITI [23], while San Francisco State University

requires "all researchers using research volunteers to pass an online research training course," and provides links to both NIH and CITI courses [24]. Other institutions—e.g., Vanderbilt University School of Medicine [25], Duke University School of Medicine [26] —require completion of in-person courses or other educational programs developed by the institution to address NIH educational requirements for research carried out with human subjects.

Professional journals frequently require that authors reporting findings of social/behavioral or biomedical research with human subjects attest that the study presented adhered to human subjects protections and appropriate oversight. The International Committee of Medical Journal Editors (ICMJE) recommends that investigators ensure that "the planning, conduct, and reporting of human research" is in accord with the Declaration of Helsinki, the international statement of research ethics promulgated by the World Medical Association [27]. The *Journal of the American Medical Association* and JAMA Network journals, for example, require that authors of manuscripts reporting studies that involve human participants or animals submit documentation demonstrating formal review and approval (or waiver) of the research and describe the review and its determination [28]. *Annals of Internal Medicine* likewise requires authors to confirm appropriate review or affirm that the research reported is consistent with the principles of the Declaration of Helsinki [29], while *The Lancet* advises prospective contributors that it adheres to the ICMJE *Recommendations* [30].

AMA POLICY

Policy H-460.980, "Ethical and Societal Considerations in Research," first adopted in 1987, provides that "All investigators involved in research projects should be responsible for the clear articulation and enforcement of standards that ensure the integrity of scientific data and conclusions." The AMA *Code of Medical Ethics* sets out expectations for ethical conduct for physician-investigators substantively in keeping with federal human subjects protections in opinions E-7.1.1, "Physician Involvement in Research"; E-7.1.2, "Informed Consent in Research"; E-7.1.3, "Study Design and Sampling"; E-7.1.4, "Conflicts of Interest in Research"; E-7.1.5, "Misconduct in Research"; and E-7.2.1, "Disseminating Research Results."

CONCLUSION

Oversight of research that involves human participants must balance important interests of science, the community, and individuals. Commitment to protecting the well-being and rights of individuals who agree to participate in research is fundamental to the ethics of the medical profession and to public trust.

Significant attention has been given in recent years to enhancing the system of research oversight in ways that sustain robust protections for human participants while streamlining processes of review and oversight and minimizing the burden on investigators. As scholars recently noted in relation to the Common Rule, "In an age of big data and cybersecurity threats, and as new technologies reveal personal identities, ethics rules become even more important. Federal oversight will remain the bulwark against unethical practices. In the end, treating human research participants with respect and fairly is essential for continuing public support of vital scientific investigations" [31].

RECOMMENDATION

In light of the importance of protecting the well-being and rights of research participants and the considerations reviewed above, your Board of Trustees recommends that the following be adopted in lieu of Resolution 11-A-17, "Revision of Researcher Certification and Institutional Review Board (IRB) Protocols," and the remainder of the report be filed:

> That our AMA continue to support efforts to improve protections for human subjects of biomedical and behavioral research and advocate for change as opportunities arise.

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27. POLICY AND ECONOMIC SUPPORT FOR EARLY CHILD CARE
(RESOLUTION 416-A-17)

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Resolution 416-A-17 was referred. Introduced by the New England Delegation and the Minority Affairs Section, Resolution 416-A-17 asked that our American Medical Association (AMA) advocate for: (1) improved social and economic support for paid family leave to care for newborns, infants, and young children; and (2) federal tax incentives to support early child care and unpaid child care by extended family members.

BACKGROUND

Increases in paid parental leave were associated with decreases in perinatal, neonatal, post-neonatal, infant, and child mortality in a sample of 18 Organization for Economic Co-operation and Development countries.[1]

Unpaid maternal leave provided through the Family and Medical Leave Act of 1993 (FMLA) in the US was associated with decreases in neonatal, post-neonatal, and infant mortality, but only among women who were married and had graduated from college, suggesting that women of lower socioeconomic position were unable to benefit from unpaid leave.

Although the FMLA requires larger employers to provide unpaid job-protected time off, there is no current federal law that requires employers to provide paid time off for the birth or care of children. About 38 percent of employers offer paid parental leave for employees who are new parents.[2] Paid parental leave is distinct from other paid-leave programs such as short-term disability, sick days, and government-funded disability or insurance payments.[3] Smaller employers in particular are less likely to provide meaningful paid time off beyond generic vacation or sick time. Further, much of the time off that is provided as it relates to children is oriented toward the period surrounding the birth of a child and typically does not extend to infants and young children as contemplated by Resolution 416-A-17. What success there has been in providing paid parental leave has been primarily at the state and local level and with a small number of high profile employers. For example, IBM offers 20 weeks of paid maternity leave to both salaried and hourly workers who are birth mothers and offers 12 weeks of paid paternity leave for all other parents.[4]A few states have enacted paid medical and family leave laws – California, New Jersey, New York, and Rhode Island. Additionally, a number of cities have enacted paid leave policies but most are oriented toward paid sick leave. While upwards of 20 other states have proposed their own paid leave laws, none have yet enacted a law. Regarding tax incentives to support early child care, tax law changes for 2018 raised child care tax credits up to a maximum of $2000 per child. The amount of the credit is indexed by income level. The credits do not differentiate between medically related child care and general day care. This provision of the tax code already allows amounts paid to certain extended family members to be considered in the tax credit calculation under certain circumstances. For instance, if a child was sick at home and both parents had to work, a grandmother could provide care and if paid, the expense could be considered in the credit calculation, but the expenses are still subject to the maximums.

AMA POLICY

AMA policy supports voluntary employer policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave becomes necessary due to documented medical conditions (Policy H-420.979). The AMA recognizes the public health benefits of paid sick leave and other paid time off, although mandatory paid sick leave is not specifically endorsed by the AMA. Council on Medical Service (CMS) Report 3-A-16 provided a comprehensive review of sick leave and paid leave policies. The HOD adopted the recommendations in the report, which established policy supporting employer policies that provide employees with unpaid sick days to care for themselves or a family member (Policy H-440.823).

As it relates specifically to physician practices, AMA Policies for Parental, Family, and Medical Necessity Leave (Policy H-405.960) established guidelines that encourage medical group practices to incorporate and/or encourage

development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

Existing AMA policy also includes Policy H-405.954, "Parental Leave." BOT Report 9-I-17 was written and filed as an informational report, primarily to address possible expansion of the FMLA, but also made reference to paid parental leave. Policy H-405.954 states that the AMA will: "(1) encourage the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA) (a) a reduction in the number of employees from 50 employees; (b) an increase in the number of covered weeks from 12 weeks; (c) creating a new benefit of paid parental leave; and (2) study the effects of FMLA expansion on physicians in varied practice environments."

RESEARCH AND LEGISLATIVE ACTIVITIES

Currently, federal law does not require employers to provide paid family or parental leave. The FMLA requires employers of a certain size to provide medically-related unpaid time off.

The most recent effort at the federal level to provide a broad paid parental leave approach is currently stalled. The Family and Medical Insurance Leave Act ("FAMILY Act," H.R. 947/S. 337) was introduced in Congress in 2017. The bill would, among other things, provide paid family and medical leave to individuals who meet certain criteria. It would be financed through a tax on every individual and employer, and all self-employment income. Thus far, the bill has been supported by Democratic members of Congress and has seen little action since introduction. The bill as originally drafted would:

- Create a national program to provide all workers, regardless of company size, with up to 12 weeks of partially paid leave; and
- Enable workers to receive up to 66 percent of their monthly wages, up to a capped amount, during their time of leave.

The AMA has not taken a position on this bill. In 2016 the Society for Human Resources Management (SHRM) partnered with the Families and Work Institute to conduct a National Study of Employers (NSE) practices on workplace benefits, and paid parental leave was part of that study.[5] The study seems to be the most recent and relevant broad-based employer analysis of what policies are in place today for parental leave as well as trends for the future.

The NSE's surveys have been conducted five times since 2005, providing both snapshots in time and current trends in employer practices and attitudes. The 2016 study samples 920 employers with more than 50 employees, with a blend of for-profit and non-profit as well as single and multi-cite locations. Note that the findings cited below all relate to employers with more than 50 employees.

The NSE noted that despite announcements of expanded parental leave benefits from Netflix, Amazon, Microsoft, Johnson & Johnson, Ernst & Young and a few others, "The media blitz over the past few years regarding paid parental leave was not representative of the majority of U.S. employers with 50 or more employees in 2016."[5] It also noted that the average maximum number of weeks of parental and caregiving leaves did not change significantly between 2012 and 2016, and in fact the average number of weeks provided had slightly declined when looking back to pre-recession 2005. 2016 data showed that employers seemed to be more supportive of easing the transition of a parent back into the workforce upon the birth of child (81% of employers), and more supportive of work from home options (40 percent of employers), but the percentage of employers allowing at least some employees to take time off during the workday for family or personal needs without loss of pay had declined from 87 percent to 81 percent.

Another finding demonstrated that employer support for flexible work arrangements had dropped dramatically from 31 percent in 2005 to 14 percent in 2016. While definitive research was not available to explain this change, it may be that many employers had narrowed benefit offerings during the prolonged period of economic difficulty that began in 2008. While the study tended to focus more on whether employers provided time off, it did note that of those employers providing at least some pay to women during maternity leave, most (78 percent) did so by providing some type of short term disability pay. The survey also indicated that for those employers that do offer pay, 6 percent of employers offered full pay, 39 percent offered partial pay, and 11 percent said it depends on the situation. Forty-two percent of the employers responding offered no pay at all. However, in contrast to those

findings, the same report indicated that 39 percent of employers allowed employees to take time off (at least 5 days) to care for *mildly ill* children without having to use vacation days or losing pay. The implication of this particular data is that employer policies on paid time off lack consistency.

As articulated in Board of Trustees Report 9-I-17, there is an abundance of literature about the benefits of employee access to medical leave provided under existing law, much of which was summarized in CMS Report 3-A-16.[6] Paid sick leave has been increasing throughout the United States whether by state or local law mandates or decisions by employers. However, paid leave to care for others outside of paid vacation, PTO (generic paid time off), or paid sick leave is still not prevalent in the US.

Given that only a handful of states have enacted paid parental leave programs, research on their effectiveness is limited. However, what little research there is has demonstrated generally neutral to positive feedback from employers. In particular, BOT Report 9-I-17 noted California's experience:

> In California, for example, the Paid Family Leave program provides employees with up to six weeks of paid leave to care for a new child or ill family member. The program is funded by employee payroll contributions, so while employers do not face financial burden as a result of the law, they are faced with ensuring the employees' workload is covered and that gaps in staffing are filled. The program in California, however, does not assure job protection during leave, provides wage replacement at only 55 percent, and does not cover care for grandparents, grandchildren, parents-in-law, or siblings. A 10-year review of California's expansion demonstrated that the Paid Family Leave benefit promoted family well-being, improved family economic security, equalized access to leave across occupations and income levels, and bolstered businesses by reducing workforce turnover. It was also noted that overall awareness of the program among those most likely to utilize it was low, implying that utilization rates could be higher if education and outreach were improved upon. Similar outcomes have been reported for other cities and states. [7-9]

An analysis published by IMPAQ International, Inc. and the Institute for Women's Policy Research summarizes a simulation of five paid family and medical leave model programs based on working programs in three states and a federal proposal, all applied to the national workforce. The findings suggest that expansion of FMLA laws, through covering more eligible workers, replacing a larger percentage of usual earnings, and offering more weeks of paid leave would increase costs. If based on any of the five models in the simulation, the cost for benefits would range from $31 billion to $43 billion. This report also projects that a national paid family and medical leave policy, depending on the type of expansion, would increase the amount of leave taken by 6 to 11 percent annually.[10]

Some employer groups claim paid leave policies or policies that provide coverage for more employees may burden and negatively impact employer operations.

When predicting employer reactions to programs, policies and benefits related to caregiving leaves and child and elder care, the NSE research articulated four primary factors: (1) the demographics of their workplace; (2) the demographics of the workforce; (3) financial health of the employer; and (4) human resources issues such as the difficulty or ease of attracting and retaining employees as well as the costs of employee benefits.

The attitude and approach of employers is fundamental to progress on a broad national approach to paid parental leave. It is not atypical for employers to consider all four of these factors when considering what benefits to offer their employees. As it relates to paid time off, some employers are specific about how that time can be used (vacation, sick time). Other employers are more flexible ("paid time off"), wherein the employer provides a bank of paid time off that employees can use for any purpose. Employers typically review benefits offerings every year, with time off being only one of a myriad of benefits being evaluated.

As noted above, recent changes in the federal tax code increased the child care tax credit up to $2000 per child. While it may be debatable whether the increase goes far enough, it is a positive step forward toward the intent of Resolution 416 and supporting the child care efforts of people with lower economic status.

While there has been recent publicity about proposals to have some type of child care financial assistance by allowing people to draw down future Social Security benefits, it does not seem at present that such proposals will receive meaningful consideration in Congress.

DISCUSSION

The Board's review of existing research has demonstrated that despite positive health outcomes for children being cared for by their parents, meaningful progress on national policy mandating paid parental leave is unlikely in the near term. The necessary broad-based support of employers to support such policy is simply not present at this point in time. Additionally, the anti-regulatory views of the current Administration and political climate in Washington DC may not be ripe for federal policy or action on paid family leave.

The first resolve of Resolution 416-A-17 asked the AMA to advocate for improved social and economic support for paid family leave to care for newborns, infants, and young children. The Board of Trustees believes that there would be considerable challenges to pursuing a public policy that would require employers to provide paid parental leave. Nevertheless, the Board believes that HOD policy supporting paid parental leave for the care of children is good public policy. Policy H-440.823 does support employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member. As noted earlier in this report, approximately 38 percent of employers currently offer paid parental leave for employees who are new parents. Accordingly, the Board of Trustees also supports encouraging employers to offer and/or to expand these types of policies. The Board believes that state medical associations should also be encouraged to work with their state legislatures to establish and promote parental leave policies.

The second resolve of Resolution 416-A-17 asked the AMA to advocate for federal tax incentives to support early child care and unpaid child care by extended family members. As previously noted in this report, recent changes to Federal tax law have raised child care tax credits to a maximum of $2000 per child, beginning in 2018. The expense of paying extended family members to perform child care can be considered in the calculation of this credit under certain circumstances.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the following be adopted in lieu of Resolution 416-A-17 and the remainder of this report be filed:

1. That our AMA reaffirm Policy H-440.823, "Paid Sick Leave," which recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member.

2. That our AMA encourage employers to offer and/or expand paid parental leave policies.

3. That our AMA encourage state medical associations to work with their state legislatures to establish and promote paid parental leave policies.

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28. MANDATORY PUBLIC HEALTH REPORTING OF LAW ENFORCEMENT-RELATED INJURIES AND DEATHS (RESOLUTION 417-A-17)

Reference committee hearing: see report of Reference Committee D.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 417-A-17
REMAINDER OF REPORT FILED**
See Policies H-145.975 and H-515.955

INTRODUCTION

Resolution 417-A-17, "Mandatory Public Health Reporting of Law Enforcement-Related Injuries and Deaths," introduced by the New England Delegation and the Minority Affairs Section and referred by the House of Delegates asked:

> That our American Medical Association encourage the Centers for Disease Control and Prevention and state departments of health to collect data on serious law enforcement-related injuries and deaths and make law enforcement-related deaths a notifiable condition.

BACKGROUND

Legal intervention deaths represent a small portion of violent deaths (1%) and homicides (4%) in the United States each year.[1] However, data suggest that legal intervention deaths increased 45% between 1999 and 2013.[1] Males aged 10 or older represent 96 percent of these deaths.[2] From 2010 – 2014, the mortality rate for legal intervention deaths among non-Hispanic Black and Hispanic individuals was 2.8 and 1.7 times higher, respectively, than that of White individuals.[2] In the United States, there have been several recent, high-profile cases involving the use of lethal force by law enforcement, particularly in minority communities, which have led to protests and some incidents of civil unrest.[1,4] These events erode the relationship between law enforcement agencies and the populations they serve.[3]

Testimony at the reference committee hearing was mostly supportive of the intent of this resolution. However, confusion was evident regarding whether this data was already being collected, as well as around certain definitions.

Definitions

At the state level, jurisdictions can require the reporting of cases of specific infectious and noninfectious conditions to public health agencies, this is typically referred to as a "reportable condition."[5] A "nationally notifiable condition" refers to conditions that state health departments have agreed to voluntarily report to the Centers for Disease Control and Prevention (CDC).[5] The Council on State and Territorial Epidemiologists, with input from CDC, maintains and periodically revises the list of nationally notifiable diseases and conditions.

Surveillance case definitions enable public health officials to classify and count cases consistently across various reporting jurisdictions. A standard, agreed upon definition of "law enforcement-related deaths" is lacking.

In the literature, such deaths are typically referred to as "legal intervention deaths," based on the definition from the International Classification of Diseases 10th Revision (ICD-10). "Legal intervention deaths" are defined as "a death in which a person is killed by a law enforcement officer or other peace officer (i.e., a person with specified legal authority to use deadly force), including military police, while on duty."[6] This category excludes legal executions. It does not depend on whether the resulting injury was lawful or whether injuries were inflicted intentionally. Legal intervention death is the case definition used in reporting data on this issue to public health agencies.

Other case definitions include, "arrest-related deaths," which captures (1) "all deaths attributed to any use of force by law enforcement personnel acting in an official agency capacity;" (2) "any death that occurs while the decedent's freedom to leave is restricted by a state or local law enforcement agency prior to, during, or following an arrest;" and, (3) "any death that occurs while confined in lockups or booking centers."[7] Data on "use-of-force deaths"

include "actions by a law enforcement officer as a response to resistance that results in the death or serious bodily injury of a person or when a law enforcement officer, in the absence of death or serious bodily injury, discharges a firearm at or in the direction of a person."[8]

Law enforcement-related deaths could also encompass law enforcement officer homicides, which are defined to capture deaths of law enforcement officers killed in the line of duty or those acting in an official capacity.[9]

DISCUSSION

Surveillance systems can help researchers and public health agencies examine data and identify patterns or associations that can inform preventive actions. Multiple systems currently exist that collect information regarding law enforcement-related deaths. These include both governmental and non-governmental reporting systems. Governmental reporting systems are either housed in law enforcement agencies or public health agencies. Data collected varies by system, with a number of different types of cases being reported from different sources. Most non-governmental systems were created by the media to try to develop a more accurate data set than what is available from governmental reporting systems.

Governmental Reporting Systems

There are four reporting systems that have been used by the government to collect data on law enforcement-related deaths, the Federal Bureau of Investigation's (FBI's) Uniform Crime Reporting (UCR) program, the Bureau of Justice Statistics (BJS) Arrest-Related Deaths (ARD) program, the CDC's National Vital Statistics System (NVSS), and National Violent Death Reporting System (NVDRS).

The BJS ARD program was designed as an annual, national census of persons who died during the process of arrest or while in the custody of state or local law enforcement.[10] In addition to deaths caused by the use of force by law enforcement personnel, it also captures those not directly related to law enforcement action, such as suicide, intoxication, accidental injury, illness, or natural causes. ARD was established as a state-based reporting system in which state reporting coordinators in all 50 states and the District of Columbia are responsible for identifying and reporting all eligible cases.[10] In 2014, BJS determined that the ARD data did not meet BJS data quality standards, and therefore suspended data collection and publication.[10] In 2016, BJS announced a program redesign which relies on a mixed method, hybrid approach involving data collected from media sources and reporting from law enforcement agencies.[7]

The FBI's UCR program collects data from more than 18,000 law enforcement agencies nationwide and reports information on law enforcement officers killed and assaulted, justifiable homicide, and crime data statistics.[8] The FBI has agreed to work with other organizations, including the BJS and the law enforcement community, to gather and report data on officer-involved use-of-force incidents. Participation is open to all local, state, tribal, and federal law enforcement and investigative agencies.[8] Each law enforcement agency will be responsible for reporting information for its own officers connected to incidents that meet the criteria of the data collection. The goal is to provide an aggregate view of the incidents reported and the circumstances, subjects, and officers surrounding the incidents.[8]

The CDC's NVDRS is a state-based surveillance system that links information on violent deaths, including legal intervention deaths, from three required sources – death certificates, coroner/medical examiner reports, and law enforcement reports – into a single system to create a more complete picture of the circumstances that lead to violent death.[11] NVDRS also captures homicides of law enforcement officers. Currently 40 states, the District of Columbia, and Puerto Rico are funded under a cooperative agreement with CDC to operate NVDRS. The goal is to eventually have a national system, with all 50 states, U.S. territories and the District of Columbia funded to participate.

The CDC's NVSS has captured legal intervention deaths since 1949.[12] NVSS receives electronic mortality data from death certificates from all 50 states, the District of Columbia, New York City, and 5 territories.[13] The NVSS' reliance on death certificate data has resulted in the underreporting of legal intervention deaths due to coroners or medical examiners failing to mention police involvement in the death certificate's cause of death section or possibly due to coding errors at the CDC's National Center for Health Statistics.[12]

Non-governmental Reporting Systems

A number of non-governmental systems have begun to track legal intervention deaths in the United States because a comprehensive national database is lacking. The Counted, a project by the Guardian, seeks to count the number of people killed by police and other law enforcement agencies in the United States through verified, crowdsourced information.[14] The *Washington Post's* Fatal Force database tracks fatal shootings by U.S. police officers.[15] Fatal Encounters, has sought to create a comprehensive national database of people who are killed through interactions with law enforcement since January 1, 2000.[16] These systems utilize media reports, public records, and social media reports to help identify cases.

Existing State Public Health Reporting Requirements

In Tennessee, the state bureau of investigation is required to provide the commissioner of health and the general assembly a report on all law enforcement-related deaths that occurred in the prior calendar year. "Law enforcement-related deaths" is defined to include: (1) the death of an individual in custody, whether in a prison, in a jail or otherwise in the custody of law enforcement pursuant to an arrest or a transfer between institutions of any kind, or (2) the death of an individual potentially resulting from an interaction with law enforcement, while the law enforcement officer is on duty or while the law enforcement officer is off duty, but performing activities that are within the scope of the officer's law enforcement duties, without regard to whether the individual was in custody or a weapon was involved.[17] While jurisdictions participating in NVDRS are required to report legal intervention deaths and law enforcement officer homicides, Tennessee appears to be the only state with a statute in place requiring the reporting of legal intervention deaths to the public health agency.

CONCLUSION

Various reporting systems exist to capture a range of different types of law enforcement-related deaths. However, no one system or case definition is perfect. Resolution 417-A-17 specifically relates to public health surveillance. NVDRS and NVSS are the existing public health reporting systems that capture legal intervention deaths and law enforcement officer homicides. Both systems have their strengths and weaknesses. NVDRS captures information from multiple sources and is therefore less likely to miss cases. However, it is not currently a national system. NVSS is a national system, but uses data from death certificates, which are often inaccurate or incomplete.[12] Since NVDRS is a more comprehensive public health surveillance system that collects information on both legal intervention deaths and law enforcement officer homicides, it makes sense to encourage its expansion to all states and territories. NVDRS is a state-based surveillance system; therefore it also seems reasonable to encourage the reporting of this information to state public health agencies. Increased public health surveillance will be useful for measuring the need for and effects of interventions to address such deaths.

CURRENT AMA POLICY

Existing AMA Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," encourages the National Academies of Sciences, Engineering, and Medicine to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities and encourages the CDC as well as state and local health departments to research the nature and public health implications of violence involving law enforcement. Policy H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," supports increasing funding for and the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 417-A-17 and the remainder of the report be filed.

1.   That current AMA Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," be amended by addition and deletion to read as follows:

H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes"

Our AMA: 1. ~~Our AMA~~ Eencourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities. 2. ~~Our AMA~~ Aaffirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health. 3. ~~Our AMA~~ Eencourages the Centers for Disease Control and Prevention as well as state and local <u>public</u> health ~~departments and~~ agencies to research the nature and public health implications of violence involving law enforcement. <u>4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies. 5. Encourages appropriate stakeholders, including but not limited to the law enforcement and public health communities, to define "serious injuries" for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.</u>

2.   That current AMA Policy H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," which supports increased funding for and the expansion of the National Violent Death Reporting System to all 50 states and territories be reaffirmed.

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**29. SUPPORT FOR SERVICE ANIMALS, EMOTIONAL SUPPORT ANIMALS, ANIMALS
IN HEALTHCARE, AND MEDICAL BENEFITS OF PET OWNERSHIP
(RESOLUTION 508-A-17)**

Reference committee hearing: see report of Reference Committee E.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 508-A-17
REMAINDER OF REPORT FILED**
See Policy H-90.966

INTRODUCTION

At the 2017 Annual Meeting, Resolution 508-A-17, "Support for Service Animals, Emotional Support Animals, Animals in Healthcare, and Medical Benefits of Pet Ownership," introduced by the Medical Student Section and referred by the House of Delegates (HOD), asked:

> That our AMA (1) recognize the potential medical benefits of animal-assisted therapy and animals as companions; and (2) encourage research into the use and implementation of service animals, emotional support animals and animal-assisted therapy as both a therapeutic and management technique of disorders and handicaps when expert opinion and the scientific literature show a potential benefit.

Considerable confusion exists in differentiating service animals, emotional support animals (ESAs), and companion animals as well as the role of animals in animal-assisted therapy (AAT). This report will define the different categories of assistance animals and outline the current landscape of evidence related to the use of animals in medical treatments.

BACKGROUND

Lack of clarity and confusion exist regarding the terms used to designate the function and role of animals used for emotional support, comfort, and therapy. Individuals with disabilities may use animals for a variety of reasons, so a clear vocabulary is necessary to advance the science and communicate findings across these disciplines.[1]

Differentiating factors in the categorization of animals include: 1) the animal's ability to provide assistance that is related to an individual's disability; 2) whether assistance or support provided by the animal requires either a basic or advanced skill level (basic skills are synonymous with simple obedience while advanced skills are more complex or specialized tasks); and 3) whether a public service, military, or healthcare professional uses the animal to assist in the implementation of a specific public service task or health-related treatment plan (the primary care-giver for the animal is not the person with the disability).

CATEGORIES OF ASSISTANCE ANIMALS

Service Animal

As defined by Title II and Title III of the Americans with Disabilities Act (ADA), a service animal is a dog (or in some circumstances, miniature horse) "that is individually trained to do work or perform tasks for the benefit of an individual with a disability including a physical, sensory, psychiatric, intellectual, or other mental disability."[2] The work or tasks performed by a service dog must be directly related to the individual's disability and that individual is the primary handler and care-giver of the animal. The ADA definition specifically excludes dogs whose sole function is to provide comfort or emotional support. Service animals have broad access to public locations, but access may be prohibited when their presence results in changes to normal business practice or when their presence poses health or safety risks.[2] These animals have an advanced level of training and nationally-recognized certification programs are available but not mandated.[1,3] Service dogs receive up to two years of training, and can cost more than $40,000. Current demand exceeds availability, and some individuals may wait for several years. The primary care-giver of the dog is often required to live at a training center for a period of time to receive training as well. Guide dogs, autism dogs, psychiatric service dogs, and diabetic alert dogs are examples of trained service animals. Other species of animals, either domestic trained or untrained, are not considered service animals.

During air travel, the Air Carrier Access Act protects the rights of passenger with disabilities and must permit a service animal to accompany a passenger with a disability. Identification cards, other written documentation, presence of harnesses, tags, or the credible verbal assurances of a qualified individual with a disability using the animal qualify as evidence that the animal is a service animal.[4]

Public Service or Military Animal

Public service or military animals have been trained in advanced skills to provide work or tasks to assist public service or military professionals in performing their duties.[1] Cadaver dogs, search-and-rescue dogs, and police dogs are examples of public service animals.

Therapy Animals

Therapy animals are trained in either basic or advanced skills to assist a healthcare professional qualified within the scope of a therapeutic treatment plan. These animals are used by professionals for AAT to help their patients or clients achieve treatment goals. The therapy is conducted under the guidance of a responsible healthcare professional and the treatment is conducted according to accepted practices and ethical principles, which include adequate training of the professional to work with the animal.[1] Therapy animals have limited access to public locations and are often under the care of the professional who oversees the AAT. The patient receiving the AAT is not the care-giver of the animal.

Visitation Animals

Visitation animals are trained in basic skills to provide comfort and support to individuals through companionship and social interaction primarily in nursing homes, hospitals, and schools.[1] Visitation animals are not required to be accompanied by healthcare professionals and are usually handled and owned by community volunteers.[1]

Emotional Support Animals

ESAs provide physical, psychiatric, or emotional support to individuals primarily in their home. No standards exist for the training of ESAs, which usually have only basic obedience skills because they are primarily owned pets.[1,3] ESA access to public locations is limited. Their rights are governed by the Fair Housing Act of 1988 (FHA) which states that ESAs can reside in both public and private housing with proof of need for an ESA. Under Federal Department of Housing and Urban Development regulations, an animal qualifies as a support animal if an individual has a disability, an animal is needed to assist with a disability, and the individual demonstrates that there is a relationship between the disability and the assistance that the animal provides.[1] Proof of need is most easily, and often, conveyed with a letter from a physician describing the necessity of an animal to a person's specific disability. Of note and according to the ADA, a letter from a physician stating the person has a disability and needs an animal for emotional support does not mean that animal qualifies as a service animal.[2]

According to federal regulations, airlines are not required to accept ESAs unless passengers provide current documentation on the letterhead of a licensed mental health professional (e.g., psychiatrist, psychologist, licensed clinical social worker, including a medical doctor specifically treating the passenger's mental or emotional disability) stating: 1) the passenger has a mental or emotional disability recognized in the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM IV); 2) the passenger needs the ESA as an accommodation for air travel and/or for activity at the passenger's destination; 3) the individual providing the assessment is a licensed mental health professional, and the passenger is under his or her professional care; and 4) the date of the documentation and the mental health professional's license information.[4]

No certification or registration standards exist for ESAs; however, many online agencies claim to "register" an ESA for a fee, offer identification cards, kits with identification vests, and some provide healthcare professional letters for a fee.[5-8] The industry that has developed around the certification of ESAs to allow pet owners to have their animals with them in restricted housing and on flights at no cost has raised concerns from both professional and ethical standards perspectives.[9]

SERVICE ANIMAL AND EMOTIONAL SUPPORT ANIMAL POLICY

The recent proliferation of service dogs and ESAs has led to individuals taking advantage of unclear policies and misrepresenting animals as service animals.[3] The ADA permits only two questions to be asked of people with service animals: 1) Is the dog a service animal and 2) what task is the dog trained to perform? No additional inquiry can be made regarding a disability, and no proof of service dog status can be requested. No federal licenses or documents to prove service dog status exist, but some states do have "assistance animal" registries for service dogs with the intended purpose of making access to public places easier for the animal and handler.[10] A recent study of assistance dog registrations in California revealed that registrations have increased sharply in the past decade and that tags have been mistakenly issued to ESAs, some cats, and dogs not fitting the definition of assistance dogs under the law.[11]

Although there is substantial variation in scope and penalty, nineteen states have laws against the fraudulent representation of a service animal.[12,13] Other states are considering legislation against fraudulent ESAs.[13,14] Furthermore, proposed federal legislation amending the Air Carrier Access Act includes ESAs in the definition of service animals.[15]

True service dogs are essential for the well-being of their human owners and both humans and the service dogs are put at risk by untrained dogs in public places. Advocates for laws against service dog fraud, as well as responsible pet owners, have voiced opinions that new legislation should include public education efforts on legitimately trained service dogs and the distractions imposed by untrained pets and the need for a national certification program and registry for legitimately trained service dogs.[13,16]

Few studies have addressed the public health risks of animals in the healthcare setting and the limited research that has been conducted indicates cause for concern. For example, methicillin-resistant *Staphylococcus aureus* (MRSA) has increasingly been described in cats and dogs making these animals a potential source of MRSA exposure in healthcare facilities.[17] In a survey of U.S. hospitals, elder care facilities, and therapy animal organizations, health and safety policies for therapy animals varied significantly and many did not follow recommended guidelines for animal visitation, potentially compromising human and animal safety.[18,19]

EVIDENCE RELATED TO THE USE OF ANIMALS IN MEDICAL TREATMENTS

Limited evidence exists regarding the use of animals for treatments of individuals. Evidence of benefits of AAT and animals as companions is limited in depth because the sample sizes of the few clinical trials are either too small to produce reliable results or there is little evidence that the improvement is due to the presence of the animal as opposed to interacting with the animals' sympathetic handlers. Additionally, study authors note the need for longitudinal follow-up studies to verify the stability of a therapeutic effect attributed to the AAT on the patients. Of the limited and relatively low quality randomized controlled trials identified, approximately half involved "mental and behavioral disorders" and the types of animal interventions included dog, cat, dolphin, bird, cow, rabbit, ferret, and guinea pig.[20-25] Numerous examples of individual case studies and individual clinical anecdotes exist in the literature.[26]

The American Veterinary Medical Association (AVMA) and others have researched the benefits of pet ownership and maintain resources detailing the work.[27-29] The Human-Animal Bond Research Initiative (HABRI) Foundation and the Purdue University College of Veterinary Medicine maintain an online platform for open research and collaboration regarding the relationships between humans and their pets.[30]

CURRENT AMA POLICY

AMA policy does not address the use of AAT or companion animals, but broadly addresses alternative treatments. Current AMA Policy H-480.964, "Alternative Medicine," addresses alternative therapies and states research should be done to evaluate efficacy; physicians should routinely inquire and educate themselves and their patients about alternative therapies; and that patients should be educated about any potential hazards of stopping conventional medical treatment. Policy H-295.902, "Alternative Medicine," states that medical school courses addressing alternative medicine should present the scientific view of unconventional therapies, potential therapeutic utility, safety, and efficacy.

RECOMMENDATIONS

The Board of Trustees recommends the following policy be adopted in lieu of Resolution 508-A-17, and the remainder of the report be filed:

Service Animals, Animal-Assisted Therapy, and Animals in Healthcare
Our American Medical Association:
1. Encourages research into the use of animal-assisted therapy as a part of a therapeutic treatment plan.
2. Supports public education efforts on legitimately trained service animals, as defined by the Americans with Disabilities Act (ADA).
3. Supports a national certification program and registry for legitimately trained service animals, as defined by the ADA.
4. Encourages health care facilities to set evidence-based policy guidelines for animal visitation.

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30. IN-FLIGHT EMERGENCIES
(RESOLUTION 516-A-17, RESOLVE 5)

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 516-A-17, RESOLVE 5
REMAINDER OF REPORT FILED
See Policy H-45.979

INTRODUCTION

At the 2017 Annual Meeting, Resolve 5 of Resolution 516-A-17, "In-Flight Emergencies," introduced by the Minority Affairs Section and referred by the House of Delegates (HOD), asked:

That our American Medical Association (AMA) offer medical trainees and physicians medical education courses to prepare for addressing in-flight emergencies during its meetings and/or by strongly encouraging its affiliated state and local branches to offer similar education courses.

This report will outline the current options for physician continuing medical education (CME), guidance, and policy on the topic of in-flight medical emergencies (IFMEs).

BACKGROUND

IFMEs are defined as medical events that require the attention of medical professionals or the flight staff and crew aboard an aircraft. These emergency events occur in about one out of every 604 flights, but the actual incidence of these events is unknown and this is likely an underestimate because of underreporting.[1] The most common medical emergencies are feelings of lightheadedness and dizziness, acute infections, shortness of breath, trauma, syncope, altered mental status, stroke, and acute coronary syndromes.[1]

ON-BOARD MEDICAL RESOURCES

The Federal Aviation Administration (FAA) mandates that U.S.-based airlines carry first aid kits that are stocked with basic supplies such as bandages and splints. The requirements were arrived at based on public input during a Notice of Proposed Rulemaking included in the Aviation Medical Assistance Act of 1998. At least one kit must contain the required items, and at least one automated external defibrillator (AED) must be available.[2] For international airlines, medical supply requirements are determined by the corresponding national aviation regulatory authority in collaboration with the airlines they regulate.

Ground-based medical support systems (GBMS) are widely used by airlines, especially by long haul aircraft, to provide advice to crew who are dealing with a medical emergency. The ground based medical officer can provide advice to crew and to an on board volunteer doctor since he/she is trained in the provision of aircraft related medical advice, knows exactly what is contained in a particular operator's on board medical supplies and is aware of the medical facilities in the vicinity of the aircraft, should a diversion need to be considered.

AIRLINE PROTOCOLS FOR MANAGING IN-FLIGHT MEDICAL EVENTS

When in an aircraft, the pilot, assisted by the co-pilot, has overall responsibility for the passengers, the crew, the flight, and the aircraft. Cabin crews, who are responsible for managing IFMEs are trained to recognize common medical issues and provide first aid and basic cardiopulmonary resuscitation. Cabin crew will generally make an initial assessment of a passenger in need of medical assistance and will keep the pilot informed about the situation. Crew is also responsible for requesting assistance from any onboard medical professionals if needed. The pilot can call GBMS for assistance if necessary.[3]

IFME GUIDANCE, TRAINING, AND POLICY

Congress passed the Aviation Medical Assistance Act in 1998, which protects providers who respond to IFMEs.[4] Onboard emergency medical equipment, including automated external defibrillators (AEDs) and emergency medical kits are federally regulated; minimum emergency medical kit requirements exist and AEDs are required on all airplanes of air carriers operating under CFR part 121 with a maximum payload capacity of more than 7,500 pounds and with at least one flight attendant.[5,6]

The Aerospace Medical Association (AsMA) has done extensive work to address IFMEs.[7] With the collaboration of other medical organizations, including the AMA, AsMA released a guidance document with information and/or recommendations about what the most common IFMEs are, how often they occur, necessary on-board medical supplies, appropriate cabin crew training, the need for automated external defibrillators, and legal aspects of IFMEs. In April 2016, AsMA convened an Aircraft Emergency Medical Kits Workgroup that included AMA representation. Based on the outcome of this meeting, AsMA further refined its recommendations regarding medical guidelines for airline travel/in-flight medical care, including the contents of on-board medical supply kits. These recommendations support an expanded cache of supplies compared with those required by the FAA.[8] The AsMA guidance also includes information to assist volunteer medical professionals who respond to a request for medical assistance, including advice on providing identification and proof of credentialing, inquiring about ground support, and documenting diagnostic findings and treatment.

In collaboration with the AMA, International Civil Aviation Organization (ICAO), International Air Transport Association (IATA), International Academy of Aviation and Space Medicine (IAASM), American Osteopathic Association (AOA), and American College of Emergency Physicians (ACEP), AsMA also has developed an educational and training resource document for health professionals entitled, "Managing In-flight Medical Events,".[9]

Other aviation organizations also regularly study, make recommendations on, and have informational material related to IFMEs. IATA publishes a medical manual which details protocols for IFMEs.[10,11] ICAO works in close collaboration with agencies and organizations including the World Health Organization (WHO), IATA, and Airport Council International (ACI) to provide medically related publications, training, and policy. ICAO also cooperates and consults with the chief medical officers of civil aviation authorities around the world and the Medical Directors of airline companies.[12]

Recently, a CME opportunity on the topic of IFMEs was published in the *Cleveland Clinic Journal of Medicine*.[13]

CURRENT AMA POLICY

Extensive AMA policies address IFMEs. Policy H-45.979, "Air Travel Safety," (Appendix) supports efforts to educate the flying physician public about IFMEs to help them participate more fully and effectively when an IFME occurs. Policy H-45.978, "In-flight Medical Emergencies," discusses in-flight emergency medical supplies and equipment and H-45.982, "Improvement in U.S. Airlines Aircraft Emergency Kits," urges the FAA to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices.

SUMMARY AND CONCLUSION

Although numerous publications of experiences managing IFMEs exist in the literature, many are anecdotal, based on one event, and may draw conclusions that are not necessarily applicable throughout the industry. AsMA, in

collaboration with several other organizations, has developed guidance and training for medical practitioners who volunteer to provide assistance on board an aircraft. Additionally, other resources are available to physicians interested in learning more about IFMEs. Resources available on the topic of IFMEs include:

- AsMA guidance document[9]
- IATA medical manual[11]
- Cleveland Clinic Journal of Medicine CME[13]
- In-Flight Medical Emergencies during Commercial Travel, *New England Journal of Medicine* article detailing response recommendations, consulting with GBMS, and medical kit contents[2]
- ICAO information regarding Aviation Medicine[12]
- Handling In-Flight Medical Emergencies[14]
- What to do during inflight medical emergencies? Practice pointers from a medical ethicist and an aviation medicine specialist.[3]
- FAQ: What Should Happen During an Inflight Medical Emergency[15]

Given that up-to-date educational resources are available on this topic, the Board of Trustees believes further efforts on this topic by our AMA are not necessary at this time. The extensive work by AsMA and others, as well as current AMA policy, address IFMEs in depth.

RECOMMENDATION

The Board of Trustees recommends the existing AMA Policy H-45.979, "Air Travel Safety," be reaffirmed in lieu of Resolve 5, Resolution 516-A-17, and the remainder of the report be filed.

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H-45.979, "Air Travel Safety"
Our AMA:
(1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies;
(2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and
(3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar.

31. PHYSICIAN BURNOUT AND WELLNESS CHALLENGES, PHYSICIAN AND PHYSICIAN ASSISTANT SAFETY NET, IDENTIFICATION AND REDUCTION OF PHYSICIAN DEMORALIZATION (RESOLUTIONS 601-I-17, 604-I-17 AND 605-I-17)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

INTRODUCTION

At the 2017 Interim Meeting, three resolutions (601-I-17, "Physician Burnout and Wellness Challenges," 604-I-17, "Physician and Physician Assistant Safety Net," and 605-I-17, "Identification and Reduction of Physician Demoralization") with shared components of a central issue were referred for report back together at the 2018 Annual Meeting. This report addresses the overarching topic and each resolution as it relates to the issue, and presents recommendations accordingly.

Resolution 601-I-17, "Physician Burnout and Wellness Challenges," was introduced by the International Medical Graduates Section and the American Association of Physicians of Indian Origin. Resolution 601-I-17 asks the American Medical Association (AMA) to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness.

Resolution 604-I-17, "Physician and Physician Assistant Safety Net," was introduced by the Oregon Medical Association and asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians. Resolution 604-I-17 also directs the AMA to advocate that funding for such safety net programs be sought from such entities as foundations, hospital systems, medical clinics, and donations from physicians and physician assistants.

Resolution 605-I-17, "Identification and Reduction of Physician Demoralization," was introduced by the Organized Medical Staff Section and asks that the AMA: (1) recognize that physician demoralization, defined as a consequence of externally imposed occupational stresses, including but not limited to electronic health record (EHR)-related and administrative burdens imposed by health systems or by regulatory agencies, is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness.

BACKGROUND

Today's physicians are experiencing burnout at increasing rates, expressing feelings of professional demoralization, professionally under-valued and overburdened by an ever-changing health care system.[1-3] Over 54 percent of

practicing physicians report experiencing at least one symptom of burnout, a near 10 percent increase in three years.[4] Practicing physicians are not alone in reported symptoms of burnout; resident and medical student burnout is also on the rise. It is recognized that with growing numbers of physicians, residents and medical students experiencing burnout, health care costs will continue to rise and patient safety will suffer.[5] Stress, depression and burnout can lead to suicidal ideation and sometimes suicide. While no resolute number has been verified, it is estimated and often cited that 300 to 400 physicians per year die by suicide[6], and physician suicide rates are historically higher than the general population.[7] Resources such as safety nets and hotlines exist for individuals experiencing suicidal ideation and are available from a number of national and reputable sources.

AMA POLICY

Our AMA recognizes the importance of addressing and supporting physician satisfaction as well as the impact physician burnout may have on patient safety, health outcomes and overall costs of health care. This commitment to physician satisfaction and well-being is evidenced by AMA's ongoing development of targeted policies and tools to help physicians, residents and medical students, and its recognition of professional satisfaction and practice sustainability as one of its three strategic pillars.

The AMA supports programs to assist physicians in early identification and management of stress. The programs supported by the AMA concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, as well as when to seek professional assistance for stress-related difficulties (Policy H-405.957, "Programs on Managing Physician Stress and Burnout"). AMA policy and the Code of Ethics acknowledge that when physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided (Code of Ethics 9.3.1, "Physician Health & Wellness"). Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness (Policy H-405.961, "Physician Health Programs"). Educating physicians about physician health programs is greatly important to the AMA. The AMA will continue to work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members about the availability of and services provided by state physician health programs to ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory. Our AMA will continue to collaborate with other relevant organizations on activities that address physician health and wellness. Our AMA, in collaboration with the FSPHP, develops state legislative guidelines to address the design and implementation of physician health programs, as well as messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training (Policy D-405.990, "Educating Physicians About Physician Health Programs").

The AMA recognizes physical or mental health conditions that interfere with a physician's ability to engage safely in professional activities can put patients at risk, compromise professional relationships and undermine trust in medicine. While protecting patients' well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care (Code of Ethics 9.3.2, "Physician Responsibilities to Impaired Colleagues"). AMA policy defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities. The AMA in the same policy encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians and to develop case finding mechanisms for all types of physicians (Policy H-95.955, "Physician Impairment"). Access to confidential health services for medical students and physicians is encouraged by the AMA to provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services. Our AMA will continue to urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: (a) be available to all medical students on an opt-out basis; (b) ensure anonymity, confidentiality, and protection from administrative action; (c) provide proactive intervention for identified at-risk students by mental health and addiction professionals; and (d) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. Our AMA: (a) encourages state medical boards to consider physical and

mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and, (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education (Policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians").

The AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem not only with practicing physicians, but among residents, fellows, and medical students. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets. In addition, our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. The AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community. Finally, our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements (Policy D-310.968, "Physician and Medical Student Burnout").

DISCUSSION

Our AMA is committed to upholding the tenets of the Quadruple Aim: Better Patient Experience, Better Population Health, Lower Overall Costs of Health Care, and Improved Professional Satisfaction.[8] This is evidenced by AMA policy supporting the "Triple Aim" and requesting that it be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers (Policy H-405.955, "Support for the Quadruple Aim"). In order to achieve the fourth aim, the AMA acknowledges that interventions at both system and individual levels are necessary for enhancing physician satisfaction and reducing burnout. The work carried out through the AMA's Professional Satisfaction and Practice Sustainability strategic focus area is dedicated to this objective.

Resolution 601-I-17 asks the AMA to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness. The AMA has been actively and directly engaged with health care organizations, including state and county medical societies, to build awareness and support for addressing physician burnout. The AMA partnered with the RAND Corporation in 2013 to identify and study the factors that influence physician professional satisfaction, as well as understand the implications of these factors for patient care, health systems, and health policy.[9] This seminal work informed subsequent initiatives and a long-term strategy for AMA's Professional Satisfaction and Practice Sustainability unit. Key accomplishments and offerings have been realized through launching the free, online, STEPS Forward™ practice transformation platform. This online resource offers over 50 modules of content developed by subject matter experts and is specifically designed for physicians, practices, and health systems. The STEPS Forward platform has been openly shared with leadership of many state and specialty societies, as well as presented to their membership in various forums. In addition, the AMA has partnered with health systems, large practices, state medical societies, state hospital associations and graduate medical education programs to deploy and assess physician burnout utilizing the Mini-Z Burnout Assessment.[10] The assessment offers organizations a validated instrument that provides an organizational score for burnout, along with two subscale measures for "Supportive Work Environment" and "Work Pace and EMR Frustration." In addition to the organizational dashboard, the assessment is able to provide a comprehensive data analysis complete with medical specialty and clinic level benchmarking. The trends and findings from the assessment are shared and targeted interventions are recommended to the surveying organization. The interventions and suggested solutions are curated from existing STEPS Forward content and through specific best practices identified through AMA collaborators.

Resolution 604-I-17 asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Testimony heard in the reference committee hearing

further clarified the request for a task force to research, collect, publish and administer a repository of information about programs and strategies that optimize physician wellness. The AMA, through its ongoing work in the Professional Satisfaction and Practice Sustainability strategy unit, acknowledges the importance of addressing and supporting physician mental health and has developed and published resources to help physicians manage stress and prevent and reduce burnout. The AMA supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.

In addition, our AMA will review relevant modules of the STEPS Forward program and also identify validated student-focused, high-quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students. The STEPS Forward platform currently provides relevant modules to address physician well-being, specifically the modules "Preventing Physician Distress and Suicide," "Improving Physician Resiliency" and "Physician Wellness: Preventing Resident and Fellow Burnout." In conjunction with STEPS Forward modules, the Mini-Z Burnout Assessments provide participating organizations the option to embed the PHQ-2 Depression Screening Tool. This allows organizations to gain a deeper understanding of those physicians experiencing more severe levels of depression and disinterest and correlate those responses to burnout. The survey also offers a free text section for physicians in need of services to self-identify and receive direct outreach and support. Additionally, the Mini-Z tool provides information on the National Suicide Prevention Lifeline for organizations to utilize in their physician wellness and burnout efforts.

It is demonstrated through current efforts and strategic priorities that the AMA recognizes the importance of assessment and attention to depression in physicians, residents and medical students, as well as the relationship that depression can have with suicidal ideation. Current AMA research and strategic initiatives are focused on enhancing workflows within the system and clinical setting with the intent to scale efficiency and reduce feelings of burnout amongst physicians. The AMA's role in sharing burnout and depression screening data is to assist physician employers in understanding individual physician burnout and connecting physicians with employee assistance resources. Considering the AMA's current efforts and ongoing commitment to providing resources on the topics of burnout, distress and suicide prevention, stress reduction, and wellness, convening an exclusive task force separate from the AMA staff already dedicated to this work would be duplicative. While an online search indicates there is no current, easily identifiable suicide prevention line exclusively for physicians or health care workers, there are hotlines available that are open to all individuals regardless of profession. Studying these hotlines as described in the resolution would be resource intensive and the results of such study may not prove applicable to the AMA's primary audiences; however, making existing relevant AMA resources available to physicians seeking help can be accomplished, and is part of current AMA practices. The AMA will continue to direct physicians to our current resources to learn about strategies, programs and tools related to this topic, and will further explore options for providing more direct assistance for physicians in need.

Resolution 605-I-17 asks the AMA to (1) recognize that physician demoralization is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness. Testimony in the reference committee hearing recognized that "burnout" is a commonly used term favored by many physicians, and while there is some preference for the use of another term instead of "burnout," there was no consensus on what that term should be. Our AMA recognizes that burnout is characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness. These feelings can manifest as a result from a multitude of driving factors, such as administrative burden, excessive EHR documentation and systemic cultural deficiencies leading to demoralization of physicians. The term "burnout" is often used to encompass the multiple driving factors of physician dissatisfaction as well as the resultant feelings and behaviors associated with being overworked, excessively scrutinized and overburdened with unnecessary tasks. As the term "burnout" is used broadly, this allows for many variations in the interpretation of its meaning. Our AMA does not define the term "burnout" as an individual "resilience deficiency" or character flaw. Our AMA supports and voices a position that burnout is derived from system and environmental issues, not from the individual physician. This position is evidenced by AMA resources and services targeted at system-level approaches to intervention.

In addition, the AMA will continue to advocate for organizations to confidentially survey physicians to understand local levels of burnout and opportunities for strategic improvement. It should be noted that the AMA's Mini-Z Burnout Assessment is deployed confidentially and takes protective safeguards very seriously to ensure accurate and safe reporting of results. Through leveraging ongoing AMA media channels, hosting educational webinars, live speaking engagements, and the Transforming Clinical Practices Initiative (TCPI) grant through the Centers for Medicare and Medicaid Services (CMS), the AMA is striving to scale awareness and intervention to advance physician satisfaction and help address the burnout epidemic.

CONCLUSION

The AMA is committed to enhancing joy in practice for physicians, residents and medical students. Our AMA will continue its focus on research, advocacy and activation to address the issues presented in each of the resolutions discussed herein. The AMA will continue to work diligently to address the issues through our existing work, partnerships, resource development and policies. We present the following recommendation to not only emphasize the work already being done, but also to further address the issues brought forth in these three resolutions.

RECOMMENDATION

The AMA Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 601-I-17, 604-I-17 and 605-I-17, and that the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
   a. H-405.957, "Programs on Managing Physician Stress and Burnout;"
   b. H-405.961, "Physician Health Programs;"
   c. D-405.990, "Educating Physicians About Physician Health Programs;"
   d. H-95.955, "Physician Impairment;" and
   e. H-295.858, "Access to Confidential Health Services for Medical Students and Physicians."

2. That our AMA amend existing Policy D-310.968, "Physician and Medical Student Burnout," to add the following directives:

   1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.

   2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

   3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.

   4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

   5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

   6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

   7. Our AMA will encourage hospitals to confidentially survey physicians to identify factors that may lead to physician demoralization.

8. Our AMA will continue to develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (2) develop and promote mechanisms by which organizations and physicians can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being at the system level.

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32. STUDYING HEALTHCARE INSTITUTIONS THAT PROVIDE CHILD CARE SERVICES

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2017 Annual Meeting, Policy D-215.987, "Studying Healthcare Institutions that Provide Child Care Services," was adopted by the House of Delegates. This policy directs the American Medical Association (AMA) to work with relevant entities to study healthcare institutions to determine whether they provide childcare services and report on those findings at the 2018 Annual Meeting. This report, which is presented for the information of the House, provides background on child care services in health care and the implications of access to child care for physicians, as well as results of a study conducted by the AMA and other relevant research.

BACKGROUND

Physicians and residents often work irregular, long and overnight hours. Those with young children, specifically pre-school age and younger, face significant challenges in ensuring their children are cared for during work hours. This is especially true for dual-physician couples, physicians with spouses or partners that work full time, and single parent physicians. According to a 2017 AMA study of women physicians, 56 percent of respondents indicated onsite child care is either somewhat or strongly important in helping them balance work and family responsibilities.[1] Some challenges physicians encounter in trying to secure care for their children include accessibility, affordability, and flexibility in hours. Many child care centers are full to capacity and have wait lists that keep parents waiting for months or even years before their child can be accepted.

Parents often experience stress and anxiety in dealing with family responsibilities that may affect their work.[2] Contending with the task of obtaining care for young children can increase stress, which contributes to higher rates of burnout.[3-5] Burnout can lead to diminished concentration, medical errors or misdiagnoses, lack of empathy, and lower professional satisfaction.[6] Implementing tactics to reduce personal and professional stress is associated with decreased rates of burnout[7] and having access to child care services, either onsite or near their workplace, can help alleviate stress and anxiety for parents. Research also demonstrates that employees report improved productivity while using quality child care.[8] Despite the correlations between parental stress and burnout and between access to child care and improved productivity,[9] access to onsite child care is limited for most employees.

AMA POLICY

AMA Policy H-215.985, "Child Care in Hospitals," states that the AMA: (1) strongly encourages hospitals to establish and support child care facilities; (2) encourages that priority be given to children of those in training and that services be structured to take their needs into consideration; (3) supports informing the AHA, hospital medical staffs, and residency program directors of these policies; and (4) supports studying the elements of quality child care and availability of child care on a 24-hour basis.

AMA Policy H-525.998, "Women in Organized Medicine," states that the "AMA (3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings."

DISCUSSION

Although there is evidence to show that reducing burnout and stress can lead to higher rates of job satisfaction and productivity, there is limited research showing a direct relationship between access to employer-sponsored child care services and employee productivity or job satisfaction, and what research is available is not consistent. An evaluation of existing research, published in *Personnel Psychology*, concluded there is not a credible evidence base to support the claims that employer-sponsored child care increases productivity and job satisfaction, or that it reduces absenteeism.[10] However, another more recent review demonstrates that offering onsite child care improves employee recruitment and productivity, and reduces turnover and absenteeism.[9] Notwithstanding evidence for or against its perceived or actual benefits, access to employer-sponsored child care is an important consideration for physicians when making major decisions about their practices and their families.

Only seven percent of employers in the U.S. report offering onsite child care as a benefit to their employees.[11] Employers are most likely to provide Dependent Care Assistance Plans (56 percent) which help employees pay for child care with pre-tax dollars, or Child Care Resource and Referral (41 percent), which is simply access to information about child care in the area. These options are easier to implement and less costly than offering child care at or near the worksite.[12] Employers that provide onsite child care are eligible for a federal tax credit and a state tax credit in many states. The tax credit is not applicable for funds provided to employees to assist with the cost of outside child care.

In the health care industry, access to employer-provided child care assistance is more prevalent than in other industries.[13] According to the Bureau of Labor Statistics, 17 percent of civilian workers in the health care/social assistance sector have access to an employer-sponsored child care benefit.[13] Thirty-seven percent of civilian workers

in hospitals have access to a workplace program that provides for either the full or partial cost of child care in a nursery, day care center, or a baby sitter in facilities either on or off the employer's premises.[13] According to the AMA women physician study, one in ten physicians indicated their employer offers onsite child care services, and of those, 19 percent have access to a subsidy, allowance, or discount to help cover the cost of the onsite care.[1] The majority of respondents (57 percent) who report that their employer offers onsite care work in large practices with 26 or more physicians.[1]

Residency and fellowship programs may also provide access to onsite or subsidized child care services. According to the AMA Residency & Fellowship Database® (FREIDA), which comprises information about more than 10,000 ACGME-accredited programs, 35 percent of the programs provide access to some type of child care service assistance, 3,344 offer onsite child care, 771 offer subsidies to assist with cost, and 528 offer both onsite care and subsidies.[14] Users of the FREIDA database can find details about residency programs nationwide, including whether or not they offer onsite child care or subsidies to assist with the cost of offsite child care. FREIDA is free for anyone to access and has enhanced features for AMA members.

The AMA sought collaboration from relevant stakeholders to conduct a census and capture specific data on employer-provided child care resources and assistance in the health care industry. However, since none of the organizations contacted expressed interest in pursuing the research topic, the AMA Professional Satisfaction and Practice Sustainability and Market Research groups developed and deployed the survey in-house.

The brief two-minute survey was distributed in an email invitation to 264 chief operating officers and human resource decision-makers in health care organizations. Only seven of the individuals invited to participate in the survey responded. The very small response rate could be due to a few factors: (1) the AMA does not have an established relationship with the professionals that make employee benefit decisions, so these individuals may not feel compelled to respond to an inquiry from the AMA, implying that the AMA may not be the most appropriate organization to effectively acquire this information; (2) employee benefit information may be confidential or leadership may be otherwise hesitant to share the information even on an anonymous basis; and (3) the initial target population was small due to the AMA's lack of email contact information for the designated audience, resulting in a relatively low response rate. Given the extremely small response rate it is difficult and not advisable to draw any significant conclusions from this research. Additional research is needed to understand the prevalence of employer-provided or -assisted child care; however, it is not clear that the AMA is the appropriate organization to pursue such research, given our limited access to the relevant health care human resource decision-makers and leaders who are knowledgeable about the subject.

CONCLUSION

Access to child care can help physicians and physicians in training alleviate stress and focus on their patients while at work. Reducing stress can help physicians' combat burnout and increase satisfaction in practice. Given the information available, it is apparent only a small portion of employers, including health care organizations, offers onsite child care services.[1, 12, 13] However, determining how many health care organizations offer these benefits is difficult. Some employers provide subsidies to help employees pay for child care, and others provide access to resources to help employees locate and arrange child care.

Physicians seeking employment or medical students applying for residency or fellowship may be interested in obtaining information about child care options provided by potential employers or programs. Physicians seeking employment should always ask prospective employers about child care during exploration of compensation and benefits packages. Additionally, the AMA's FREIDA database provides this information for many of the residency and fellowship programs listed. A comprehensive list of health care organizations and employers that provides employment benefit information such as availability of employer-sponsored child care could not be identified. Creating and maintaining such a list would be challenging due to limited availability of the information, limited access to the individuals that could disclose the information, the scale of the effort that would be required to collect and maintain it, and the frequency at which the information could change over time.

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33. PLAN FOR CONTINUED PROGRESS TOWARD HEALTH EQUITY
(RESOLUTION 601-A-17)

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
                    IN LIEU OF RESOLUTION 601-A-17
                    REMAINDER OF REPORT FILED**
                    See Policies H-180.944 and D-180.981

Resolution 601-A-17, "Reinstate the AMA Commission to End Health Care Disparities," which was introduced by New York, asks "that the American Medical Association reinstate the Commission to Eliminate Health Care Disparities, including goals and objectives that are Specific, Measurable, Agreed Upon, Realistic and Time Related (SMART) metrics." The AMA Board of Trustees requested, Reference Committee F recommended, and the House of Delegates approved referral of Resolution 601 for "a report back to the House of Delegates with a more comprehensive and sustainable plan for continued progress toward health equity."

BACKGROUND

In September, the Board Chair, acting on behalf the Board of Trustees, appointed a time-limited Health Equity Task Force with ten members drawn from a number of the AMA constituencies with special interest and expertise in health and health care disparities, diversity and inclusion, and health equity to advise the Board on an action plan.

The members of the Task Force are as follows:

Willarda V. Edwards, MD, MBA; Board of Trustees; Task Force Chair
Frank A. Clark, MD; Minority Affairs Section Chair
Erick A. Eiting, MD, MPH; Advisory Committee on LGBTQ Issues
Ved V. Gossain, MD; International Medical Graduates Section Governing Council
Patrice A. Harris, MD, MA; Board of Trustees
Diana E. Ramos, MD, MPH; Former member, Minority Affairs Section Governing Council
Malcolm D. Reid, MD, MPP; New York Delegation
Katrina L. Rhodes, MD, MS; YPS Assembly Delegate, American Association of Public Health Physicians
Patricia L. Turner, MD; Immediate Past Chair, Council on Medical Education
Siobhan M. Wescott, MD, MPH; Minority Affairs Section Governing Council

The Task Force was asked to adopt a definition of health equity against which proposed actions can be tested; learn from the contributions of the Commission to End Health Care Disparities; build on AMA's leadership, capabilities, and its advocacy and strategic efforts; and recommend actions and efforts that can be undertaken by AMA to positively contribute to health equity and to communicate its commitment to health equity.

The existence of gaps in health care across segments of the U.S. has been documented in previous AMA reports and in a legion of reports and articles from other credible sources. It is not the purpose of the Task Force or this report to summarize or replicate that information here. The AMA captures a selection of relevant information and data at ama-assn.org/delivering-care/reducing-disparities-health-care.

PROCESS

The Health Equity Task Force convened in person to hold facilitated discussions on December 19, 2017, and on February 11, 2018. Task Force members provided input before, between and following meetings, including reviewing interim drafts of this report. In addition, the Task Force had a large number of reports and articles at their disposal throughout the deliberations. Finally, related AMA policy was gathered and included in the Task Force resources.

At in-person meetings, the Task Force reviewed the history, actions, and achievements of the Commission to End Health Care Disparities. The Task Force was inspired by the Commission's ground work, track record, and the powerful collaborations it established. The Task Force thought it critical to honor the Commission's legacy and build upon it by taking AMA work on health equity to a new, more embedded and sustainable level and to do so with the expectation that working with other organizations will continue to be an essential component of the AMA's commitment to health equity.

The Task Force heard a presentation on current AMA work related to health equity and contributed their first-hand knowledge. Task Force members proposed a robust list of past and current tactics the AMA might energize and new ones the AMA might take on. The Task Force then received written input about each of these from staff subject matter experts. This background was considered as the Task Force reviewed and used a priority screen to rate various actions. In addition to the input from staff, a survey of Federation organizations was fielded to gather information about their work on health equity, health disparities, and diversity and inclusion. This information will serve to provide a wider window on potential future tactics and collaborations as the Task Force recommendations are implemented.

RESULTS

Definition

The Task Force reviewed a number of definitions of health equity drawn from the literature and the public records of other organizations, identifying common themes. The Task Force wished to arrive at wording that clearly conveys a guiding perspective for its recommendations and the AMA's actions going forward. A number of Task Force members penned potential definitions which were then discussed by all. Task Force members uniformly expressed a desire to keep the definition short and simple to facilitate communication to a variety of audiences. Lastly, the definition should be aspirational without caveats reflecting barriers or modifications based on possible differences in health potential.

The consensus definition is the following: **"Health Equity is optimal health for all."** This phrase reflects what the AMA is working toward and what it stands for.

It is important to note that this definition refers to all aspects of health, including mental/behavioral health, when referring to health. The Task Force was intentional in that regard so as not to imply that mental/behavioral health is distinct from health in general.

The Task Force expects that often the definition will be followed by explanations of how health equity can be achieved, including discussion of social determinants as key factors influencing health equity.

The Task Force acknowledges that the AMA and physicians cannot control all factors that need to change in order to achieve health equity. For some the AMA's role will be to identify their importance and to urge those who can have a direct role to act. Most, if not all, determinants of health must be addressed in collaboration with others. Further, individuals themselves must be engaged, but without implying that they bear full responsibility for their health outcomes.

Populations

When speaking of disparities in health, the Task Force uses the commonly understood meaning of differences in health outcomes among groups of people. Groups experiencing disparities often lack political, social, or economic power. The Commission to End Health Care Disparities focused on disparities experienced by racial and ethnic minorities. While acknowledging that those disparities have not been sufficiently addressed and should remain a high priority in the AMA work, the Task Force proposes broadening the list of populations of interest to include the many others for which disparities have been documented. The Task Force points out that these identities may have a multiplier effect when they are co-occurring, i.e., when an individual belongs to more than one disadvantaged group.

The composition of the Task Force itself represents the Board's expectation that the Task Force recommendations will be applied broadly, and is in close alignment with Healthy People 2020 (https://www.healthypeople.gov/) which points to "many dimensions of disparity," and lists "race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location" as contributing "to an individual's ability to achieve good health."[1]

In considering the list of populations to which the AMA's work might be applied, the Task Force makes the following points:

(1) Populations once thought of as "minority" may soon no longer be the minority in regard to population percentages, but disparities and inequities have endured and will continue.
(2) Wording preferences around the labels "sex and sexual identity" have continued to evolve.
(3) Though the Task Force is taking an inclusive view of health equity and populations, priorities will have to be set and target populations specified for specific change initiatives. That tension will be ongoing at the programmatic level, and making choices will be difficult. The AMA will not be able to address all needs immediately. AMA will always have finite resources and will need to make decisions about how best to leverage them.

With those caveats, the Task Force settled on the following list of population descriptors by which populations that experience health disparities may be identified: Race, ethnicity, gender, gender identity, sexual orientation, age, disability, socioeconomic status, geographic location, and educational level. The Task Force points out that the list is not intended to be exhaustive, that is, it does not preclude adding populations for which inequities in health outcomes are documented.

Strategic Framework

Having defined the health equity goal for the AMA, the Task Force identified key strategies that constitute how the AMA can work toward realizing the goal of achieving health equity. These are the big themes of work that together make up the AMA's contribution to achieving the health equity goal. This strategic framework is intended to provide enduring guideposts for a sustained effort, while appreciating that individual actions or tactics necessarily will change through time.
The Task Force proposed the following strategic framework that outlines key AMA roles, and for which tactics can be grouped:

- Advocate for health care access for all;
- Promote equity in care;
- Increase health workforce diversity and cultural awareness/competency;
- Influence determinants of health; and
- Voice and model commitment to health equity.

Several approaches cross these five framework elements. First, the AMA should partner with others. Many organizations and individuals have been working on health equity for a long time. The AMA should not re-invent

efforts where they exist and are successful, but should find opportunities for respectful collaboration so that an even greater impact can be achieved. Second, metrics should be specified to describe the outcomes expected from any activity and progress should be tracked and reported. These metrics will establish accountability for results and serve as a guide in adjusting tactics to enhance impact. Third, respect for the patient-physician relationship should be central to the AMA efforts. Engaging with patients and increasing health literacy will be necessary.

Organizational Home for Health Equity

The Task Force concluded overwhelmingly that the AMA must establish a structural or organizational component charged with looking through the health equity lens to facilitate, coordinate, and enhance current streams of work and to stimulate additional work to increase the AMA health equity footprint and impact. This recommendation is offered as the top priority of the Task Force. The characteristics of an organizational home, e.g., a "Center," should be designed to elevate the importance of and to sustain the AMA's health equity efforts.

The Task Force suggests such a home for health equity would be expected to have the following features:

- Dedicated resources, including staff and budget; an advisory body; accountability for creating a multi-year roadmap and related programmatic actions such as developing effective partnerships with a variety of stakeholders, creating and curating tools and resources for physicians, and seeking external funding sources, e.g., grants, as appropriate;
- Responsibility for facilitating and coordinating health equity work across focus areas and other organizational units and thereby stimulating and advancing health equity work;
- Authority to propose through the AMA planning process specific additional initiatives and implement those approved; and
- Accountability for developing a dashboard of metrics by which results are tracked, and responsibility for reporting on health equity efforts to the Board and, through the Board, to the HOD.

Communication

The Task Force was charged with advising on how the AMA should communicate its commitment to health equity. The creation of an organizational presence is part of doing so. An ongoing communication plan and additional definitional and explanatory materials should be developed by the health equity staff working with communications staff. It should leverage all AMA communication vehicles, including special events and AMA leadership speeches, to enable the AMA to "speak with one voice" about the importance of health equity and the AMA's commitment to action. In the end, achievements will be the foundation for demonstrating true commitment.

Tactics for Consideration

In the course of its work, the Task Force discussed a number of possible activities that might be undertaken as part of an AMA health equity roadmap and screened them by ease of implementation and potential impact.

The Task Force suggests that further vetting of specific tactics to be pursued become the responsibility of the new organizational unit as part of the AMA's planning process.

Further, the Task Force submits the following as deserving of further consideration by the dedicated health equity entity as it organizes, sets its priorities, and develops a multi-year roadmap:

- Advocate for a variety of incentives for treating currently underserved patients;
- Build upon current Improving Health Outcomes (IHO) and Accelerating Change in Medical Education (ACE) Consortium work on chronic disease prevention and treatment;
- Encourage health equity-promoting solutions through the AMA's innovation ecosystem;
- Provide grants to support specific kinds of health equity work by others; and
- Review and address as indicated lack of diversity within AMA.

RECOMMENDATIONS

The Board of Trustees recommends the following be adopted in lieu of Resolution 601-A-17 and the remainder of the report be filed:

1.   That Health Equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

2.   That our AMA develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.

3.   That the Board provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements.

REFERENCE

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**34. AMA TO PROTECT HUMAN HEALTH FROM THE EFFECTS OF CLIMATE CHANGE
BY ENDING ITS INVESTMENTS IN FOSSIL FUEL COMPANIES
(RESOLUTION 607-A-17)**

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTIONS 608 AND 607-A-17
REMAINDER OF REPORT FILED**
See Policies H-135.921 and H-135.969

At the 2017 Annual Meeting, Resolution 607-A-17 was introduced by the American Association of Public Health Physicians and referred. Resolution 607-A-17 asked that: (1) the American Medical Association (AMA), AMA Foundation (Foundation), and any affiliated corporations, work in a timely and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; (2) the AMA, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (3) the AMA support efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policymakers.

BACKGROUND

The AMA, as a science-based organization, has long supported environmental issues and spoken out on climate change, including policy H-135.973, "Stewardship of the Environment," and H-135.969, "Environmental Health Programs," that encourage physicians to be spokespersons for environment stewardship among other things; H-135.938, "Global Climate Change and Human Health," that concurs with the scientific consensus that Earth is undergoing adverse climate change and that anthropogenic contributions are significant and will create conditions affecting public health with disproportionate impacts on vulnerable populations; and finally H-135.923, "AMA Advocacy for Environmental Sustainability and Climate," outlining AMA's support of initiatives to promote environmental sustainability and other efforts to halt global climate change. (See Appendix)

The AMA also has policy prohibiting investments in the tobacco industry as part of our broad strategy to oppose tobacco use (H-500.975[5], "AMA Corporate Policies on Tobacco").

DISCUSSION

Over the past decade, groups concerned about climate change have pressured academic institutions and endowments to divest fossil fuel-related securities. While some have divested, most have decided not to do so. AMA engaged an independent advisor, Mercer Investments, to review the status of fossil fuel divestment for major investment portfolios and to perform a study evaluating the potential impact of implementing Resolution 607-A-17 and making a recommendation from an investment advisor viewpoint.

Mercer is a subsidiary of March & McLennan Companies ($13.2 Billion in revenue), and is a global leader in providing institutional investment services. It is an independent advisor that has not been involved with the AMA investment portfolios.

The AMA also received an outside legal opinion from Sidley Austin LLP, AMA's outside counsel. Sidley reviewed Resolution 607-A-17 in the context of the governing standard, the Uniform Prudent Management of Institutional Funds Act ("the Act") that is incorporated into Illinois law, the state law that governs the AMA and the Foundation.

Mercer's analysis included: (1) an overview of fossil fuel divestment among large institutional investors; (2) back tests over the last 20 years, evaluating the impact of fossil fuel divestment on both the actual AMA portfolio and market index portfolios with respect to return and risk; and (3) future return and risk projections utilizing Mercer's capital market assumptions, comparing a portfolio with no constraints and a portfolio implementing fossil fuel divestment.

The overwhelming majority of institutions have made a decision not to divest from fossil fuels. Of the largest 1,000 retirement plans, only 11 have committed to divest fossil fuels in some form. Of the 100 largest endowment and foundations, six have committed to divest in some form. The most common focus of those institutions implementing divestment has been limited to divestment of investments in coal mining companies. Divestment has not gained traction among US pension funds, due primarily to the fiduciary standard of best interest of plan participants under ERISA. The US Department of Labor (DOL) has issued an interpretive bulletin stating "fiduciaries may never subordinate the economic interests of the plan to unrelated objectives, and may not select investments on the basis of any factor outside the economic interest of the plan except in very limited circumstances." The DOL subsequently opined that fiduciaries may pursue such options but "may not accept lower expected returns or take on greater risks." While the market has seen some divestment activity, most institutions have researched divestment and decided not to proceed at this time.

As noted above, Mercer performed back tests on both the specific AMA portfolios reflecting holdings as of December 31, 2017, and index data utilizing the MSCI All Country Index, to quantify the historic impact of a divestment strategy on return, risk, and return for unit of risk. Due to data limitations, the Mercer analysis covered only market activity over the last twenty years, for the period ending December 2017. This period was dominated by low interest rates, low inflation and generally low market volatility. Over this same period, there was a general decline in energy prices. As such, this period may not be representative of future periods. Mercer's analysis of this period suggests that a divestment of fossil fuels from the AMA Reserve Portfolios is unlikely to result in a material change to return/risk expectations of the current portfolio. In particular, the analysis suggests that divestment would result in an increase in total risk (roughly 15 basis points), as would be expected by a more constrained portfolio, and this increase in risk would be partially offset by an increase of 7 basis points in expected return. While a divested portfolio in the back test period would have delivered a slightly higher return on a prospective basis, it would do so with higher risk or volatility resulting in the same return for risk measurement as the current portfolio.

Independent of the Mercer analysis, scenarios in which higher inflation, higher interest rates and greater market volatility are more prevalent must be considered in evaluating fossil fuel divestment. Specific to inflationary risk, energy holdings are likely to prove beneficial to the current portfolio relative to the divested portfolio, as historically rising inflation results in higher commodity prices, such as energy. Other academic studies, covering longer time frames and more market cycles, conclude that the estimated cost of fossil fuel divestment is significant. One such study, by Professor Daniel Fuschel of the University of Chicago, estimates a diversification cost from divesting energy stocks of approximately .5 percent per year. Another study, by Dr. Bradford Cornel of Caltech, estimates the mean risk-adjusted shortfall due to divestment at .23 percent per year. Based on the current size of the AMA's portfolio and these studies, an investment shortfall of $1.3 million to $2.9 million per year could be expected. This investment shortfall does not include other costs of divestment, such as transaction costs associated with selling and buying securities and the cost of compliance with fossil fuel divestiture goals, both of which are often material but

not estimable at this point. From a judgment perspective, consideration needs to be given to the tradeoffs of a less diversified portfolio and how relationships may change over time. From an investment perspective, not implementing a divestment process is consistent with current market practice and provides investment flexibility, particularly if the markets return to a higher growth, higher inflation environment.

In response to those who may question whether investments in fossil fuels may result in wasted capital/stranded assets, professional asset managers uniformly integrate environmental issues into their investment due diligence and decision-making process. These professional asset managers weigh valuation against risk and opportunities, including environmental issues. Markets are efficient and expectations of future states and events are factored into security prices.

Sidley Austin noted that one of the duties imposed by the Act is "An institution shall diversify the investments of an institutional fund unless the institution reasonably determines that, because of special circumstances, the purposes of the fund are better served without diversification". Since Resolution 607-A-17, if adopted, would potentially rule out a large sector of the economy (dissimilar to the AMA's policy restriction on investment in tobacco, which is a much smaller sector), Sidley opined that such a resolution "would unduly interfere with the fiduciary obligations of the AMA Board of Trustees and the Board of Directors of the Foundation to manage the assets of these organizations in a fiscally prudent manner." Sidley stated that its belief is that "the related objectives of (1) managing assets so as to produce a reasonable return without undue risk and (2) diversification of investments to achieve this result would require managers of the assets of the AMA and the Foundation at least to have the option of investing in the fossil fuel sector of the economy. If these managers concluded that investment in fossil fuel companies and related enterprises was not necessary to achieve a reasonable return with reasonable risk, they would not have to make such investments. But absolutely to preclude such investments would be to tie the hands of these managers in a way that would prevent them from carrying out their responsibilities under the Act."

The Sidley Austin legal opinion also noted that there is a critical distinction between the current AMA policy on investments in tobacco companies and the proposed resolution on investment in fossil fuel companies. Importantly, the tobacco industry is a far less substantial portion of the economy than the fossil fuel industry and the companies that depend on or serve that industry. The tobacco sector represents only 1% of the MSCI All World Index, while fossil fuels represent 6% of the MSCI All World Index. Sidley Austin concluded that with regard to investments in tobacco stocks, the current AMA policy does not materially prevent AMA asset managers from exercising the care that an ordinarily prudent person in a like position would exercise. By contrast, ruling out any investment in fossil fuel companies and in enterprises which depend on or serve those companies would place a very major constraint on AMA asset managers.

CONCLUSION

Given the results above, with a bias towards maintaining diversification and flexibility, Mercer recommends against implementing a divestment requirement. Rather, Mercer recommends the decision concerning exposure to energy sector investments remain with the AMA's selected investment managers. As noted above, a broad number of companies across industries are involved in fossil fuels, resulting in divestment from them having a much more significant impact on the diversification of the portfolio. In addition, not implementing a full divestment process is consistent with the approach taken by most major endowments and pension funds in the United States.

Sidley's opinion concludes that the proposed resolution, if adopted, "would unduly interfere with the fiduciary obligation of the AMA Board of Trustees and the Board of the AMA Foundation to manage the assets of these organizations in a fiscally prudent manner." The Board believes it should not be handicapped in fulfilling its fiduciary duty.

The Board shares a strong belief in the scientific consensus on global climate change and its threats to public health, especially for vulnerable populations. However, given the number of companies involved in fossil fuels and the Board's fiduciary obligations outlined in this report, the Board believes it should focus on legislative, regulatory, and other policy efforts as called for in existing House policy to address the threats of climate change.

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RECOMMENDATION

Based on the above analysis, the Board of Trustees recommends:

1. That Resolution 607-A-17 not be adopted;

2. That our American Medical Association, AMA Foundation, and any affiliated corporations work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels;

3. That our AMA choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and

4. That our AMA support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers, and the remainder of this report be filed.

APPENDIX - AMA Policy

H-135.973, Stewardship of the Environment
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

H-135.969, Environmental Health Programs
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.

H-135.938, Global Climate Change and Human Health
Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. 2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for

Public Health Preparedness and Disaster Response assist in this effort. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

H-135.923, AMA Advocacy for Environmental Sustainability and Climate
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

35. MODEL HOSPITAL MEDICAL STAFF BYLAWS
(RESOLUTION 609-A-17)

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED**
                      IN LIEU OF RESOLUTION 609-A-17
                      REMAINDER OF REPORT FILED
                      See Policy D-235.982

At the 2017 Annual Meeting, the House of Delegates referred Resolution 609, "Model Hospital Medical Staff Bylaws." Resolution 609-A-17, which was introduced by the Organized Medical Staff Section, asks the AMA to:

1. develop model hospital medical staff bylaws that incorporate currently believed to be best practices, meet the requirements of the Medicare Conditions of Participation, hospital accreditation organizations with deeming authority, and state laws and regulations, including annotations to show the source of all legal, regulatory, and accreditation requirements;

2. post this resource on the AMA website, continuously updated and available on demand to medical staffs, medical staff offices, and medical society staff, and widely distributed as an adjunct to the next edition of the AMA Physician's Guide to Medical Staff Bylaws; and

3. ask the legal counsels of State Medical Societies to outline state specific restrictions of medical staff self-governance so that these may be posted on the AMA-OMSS website for use by all AMA members.

BACKGROUND

The *Physician's Guide to Medical Staff Organization Bylaws* (the "Bylaws Guide") is the AMA's primary repository of information for physicians on medical staff governance, and one of the only available resources in the country addressing these matters from the physician's perspective.[1] Weighing in at more than 250 pages, the Bylaws Guide comprehensively addresses all major elements of medical staff bylaws with substantial discussion of each topic, including links to and citations of selected laws and regulations, accreditation standards, case law, and relevant AMA policy. See the Appendix for a complete list of topics covered in the Bylaws Guide.

For each topic covered, the Bylaws Guide also presents sample bylaws language that has been broadly structured to fulfill Joint Commission and other accreditation requirements and to support AMA policy on self-governance and other relevant medical staff topics. Nevertheless, the Bylaws Guide is not intended to be used as a "model bylaws" document. Rather, medical staff bylaws must be tailored to suit the needs of particular medical staffs, which differ along multiple dimensions, including nuances of state law, varying hospital accreditation organization requirements, and widely diverging hospital and medical staff characteristics. These differences substantially affect not only how individual bylaws provisions must be constructed but also which provisions should be included in the first place. Discussion

Model medical staff bylaws

Resolution 609-A-17 asks the AMA to create a set of model medical staff bylaws that can account for all of these differences. Unfortunately, there are simply too many permutations to produce a single, coherent set of model bylaws that would be any more useful than the illustrative content already included in the Bylaws Guide. One alternative,

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 609-A-17, and that the remainder of the report be filed:

1. That our AMA continue to update the *Physician's Guide to Medical Staff Organization Bylaws* to address emerging issues in medical staff affairs, including relevant changes to medical staff regulatory and accreditation requirements, such as those outlined in the Medicare Hospital Conditions of Participation and in the accreditation standards of The Joint Commission and other hospital accrediting organizations.

2. That our AMA develop guidance for physicians on key state-by-state differences in medical staff bylaws requirements and best practices, and work with state medical societies to catalog state-specific medical staff resources available to physicians.

3. That our AMA pursue opportunities to improve the accessibility and usability of the content contained in the Physician's Guide to Medical Staff Organization Bylaws, including but not limited to development of supplemental materials such as education modules, checklists, and so forth.

REFERENCES

1. The Bylaws Guide is available for free to AMA members and for $149 to non-members through the AMA Store: https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2810007.
2. The module is now available through the AMA Education Center: https://cme.ama-assn.org/Activity/5976608/Detail.aspx.

APPENDIX - Table of Contents, *Physician's Guide to Medical Staff Organization Bylaws*

How to Use this Guide

1. Bylaws: The Basics
    1.1 Medical Staff Self-Governance
    1.2 Medical Staff Bylaws as a Contract
    1.3 "Compacts" versus Bylaws
    1.4 Compliance with Accreditation and Regulatory Requirements
    1.5 System Bylaws
    1.6 Medical Staff Unification and Disunification
    1.7 New Bylaws?
    1.8 Joint Commission Standard MS.01.01.01: Improve Bylaws and Promote Self-Governance
        1.8.1 Required Bylaws Content
        1.8.2 Delegation of Authority
        1.8.3 Binding Effects on Signatories
    1.9 Splitting the Bylaws?
    1.10 Improving the Bylaws
    1.11 Independent Medical Staff Counsel

2. Preliminaries
    2.1 Preamble and Statement of Purpose
    2.2 Definitions
        2.2.1 Clinical Privileges
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3. Membership Qualifications, Rights, and Responsibilities
    3.1 What does Membership Mean?
    3.2 The Right to Practice
    3.3 Basic Qualifications for Membership
    3.4 Eligible Professions
    3.5 Nondiscrimination
    3.6 Participation in Third-Party Arrangements or Other Interests
    3.7 Health Status, Including Aging
    3.8 Criminal/Credit Clearance

36. MANAGEMENT OF PHYSICIAN AND MEDICAL STUDENT STRESS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2017 Annual Meeting, Policy D-405.982, "Management of Physician and Medical Student Stress," was adopted by the House of Delegates. This policy directs the American Medical Association (AMA) to produce a report on administrative and regulatory burdens placed on physicians, residents and fellows, and medical students, and pursue strategies to reduce these burdens. This report, which is presented for the information of the House, outlines various administrative and regulatory processes that adversely affect medical students, residents, and physicians. It also discusses AMA's efforts, including existing policies, to reduce administrative burdens and address physician stress and burnout, one of the major effects of overwhelming and burdensome mandates, tasks and processes.

BACKGROUND

Physicians, residents and medical students face work-related stresses at high rates.[1-3] Rates of stress and resulting burnout have increased in recent years, with more than 54 percent of physicians reporting at least one symptom of burnout in 2015 compared to 45 percent in 2011.[4] Forty nine percent of physicians often or always experience symptoms of burnout.[5] There are many influences, both internal and external, that contribute to stress and burnout among health professionals. Many of the external factors are imposed by administrative and regulatory factors outside of the physicians' control.

AMA POLICY

The AMA maintains numerous policies supporting physician wellness and the importance of reducing and preventing physician stress and burnout, as well as the reduction in administrative/regulatory burdens associated with medical practice that can cause stress and lead to burnout.

The AMA recognizes burnout and stress, and their effects, as serious issues that affect physicians and medical students (Policy D-310.968, "Physician and Medical Student Burnout"). AMA places great importance on physician health and wellness and the need for continued education on its importance (Policy H-405.961, "Physician Health Programs"). AMA policy and the Code of Ethics recognize that when physician health and wellness is compromised

the safety and care of the patient can be as well (Code of Ethics 9.3.1). The AMA supports programs to assist physicians in early identification and management of stress, and is committed to helping physicians, practices, and health systems identify and manage stress-related burnout (Policy H-405.957, "Programs on Managing Physician Stress and Burnout"). The AMA developed principles to guide residency programs in the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress (Policy H-310.979, "Resident Physician Working Hours and Supervision"). The AMA encourages research on the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems (Policy H-95.955, "Physician Impairment").

Reducing administrative burdens has been a top priority of the AMA for many years, and the policies on record demonstrate the AMA's continued commitment to addressing the issue at all levels. The AMA continues working to simplify administrative processes such as claims processes, prior authorizations, quality reporting, and other payer interactions (Policy D-190.974, "Administrative Simplification in the Physician Practice"; H-320.939, "Prior Authorization and Utilization Management Reform"; and D-125.992, "Opposition to Prescription Prior Approval"). The AMA advocates for the Centers for Medicare & Medicaid Services (CMS) to simplify existing requirements of federal regulations such as the Medicare and CHIP Reauthorization Act of 2015 (MACRA) and Quality Payment Program (QPP), and supports legislation that introduces improved, more streamlined solutions (Policy H-390.837, "MACRA and the Independent Practice of Medicine"; H-335.984, "Medicare Regulatory Relief Legislation"; H-180.973, "The 'Hassle Factor'"; D-320.991, "Creating a Fair and Balanced Medicare and Medicaid RAC Program"; H-385.908, "Physician-Focused Alternative Payment Models: Reducing Barriers"; H-165.838, "Health System Reform Legislation"; H-385.913, "Physician-Focused Alternative Payment Models"; H-450.946, "Ensuring Quality in Health System Reform"; and H-320.958, "Emerging Trends in Utilization Management"). The AMA supports and encourages the development of health care technology, but actively works to ensure physicians are not burdened with additional administrative tasks or processes it may create (Policy H-315.979, "Electronic Data Interchange Status Report"; D-120.984, "Streamlining the Process for Prescription Refills"; D-478.996, "Information Technology Standards and Costs"; and D-460.968, "The Precision Medicine Initiative"). Licensing, continuing medical education and maintenance of certification (MOC) have historically been cumbersome and time-consuming processes for physicians. The AMA supports efforts to increase efficiencies in some of these processes and reduce the number of cumbersome or unnecessary steps in an effort to lessen the burden on physicians (Policy D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification"; D-300.995, "Reducing Burdens of CME Accreditation and Documentation"; D-275.994, "Facilitating Credentialing for State Licensure"; H-275.917, "An Update on Maintenance of Licensure"; and H-275.924, "Maintenance of Certification").

In addition, the AMA recognizes the unique stress medical students face with student debt and career choices, and has prioritized reducing medical student debt for legislative and other action (Policy H 305.928, "Proposed Revisions to AMA Policy on Medical Student Debt"). The prospect of finishing medical school without matching to a residency program is an added stress for medical students. Due to an increase in medical students and funding caps for graduate medical education (GME) programs, this has become increasingly burdensome. The AMA has also worked with CMS and other key organizations to increase the number of GME positions in order to accommodate the increase in medical students and accommodate the projected need for more physicians (Policy D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy").

DISCUSSION

Physicians report better professional satisfaction when they perceive that they are providing high-quality care, and obstacles to providing such care are major sources of professional dissatisfaction.[6] Potential effects of physician stress and burnout include reduced empathy toward patients, poorer interactions during a visit, and medical errors, all which have the potential to decrease the quality of care.[7-11] Burnout can lead to lower professional satisfaction and a desire to reduce clinical hours or leave the practice of medicine.[5, 6] There is evidence that stress and burnout affect medical students, residents and physicians at higher rates than the general U.S. population[12, 13] and burnout has been connected to higher rates of suicidal ideation among physicians.[14-17]

In accord with the amplified attention on the effects of burnout, identifying the causes of stress and burnout has increasingly become the focus of research. Sources of stress and burnout among medical students and residents often include personal stressors, adjustment to a new work environment, ethical conflicts, financial issues, long hours, and exposure to human suffering.[12, 18] While the practicing physician can be adversely impacted with the same stressors as medical students and residents, there are additional factors that are often tied to administrative and regulatory

burdens experienced in practice. These factors affect physicians in multiple aspects of their work, including those related to the business of medicine, such as dealing with insurance companies and complying with regulatory requirements, as well as those related to the practice of medicine, such as licensing, credentialing, privileging, and maintenance of certification.

For physicians in practice, increased clerical burdens, including bureaucratic tasks and productivity requirements, are often cited as the top reasons physicians experience burnout.[5, 19-21] The amount of time physicians spend doing administrative work includes more than half their day spent completing tasks in the electronic health record (EHR) system and almost 90 minutes of EHR work at home after hours.[22] External factors detract from the quality of care physicians feel they can provide: nearly 40 percent of physicians report patient care is adversely impacted to a great degree by external factors such as third party authorizations, treatment protocols, and EHR design.[5] Physicians also report that their EHRs have reduced or detracted from the quality of care, efficiency of practice, and interaction with patients.[5]

Prior authorizations required by payers are another source of dissatisfaction and burden for physicians.[23] In a 2016 AMA study, 75 percent of physicians reported that burdens associated with prior authorization are high or extremely high in their practice, and 90 percent indicated that prior authorizations can delay patients' access to necessary care. On average, physicians or their staff complete 37 prior authorizations per week, with almost a quarter of physicians completing more than 40 per week.[24] Obtaining prior authorizations involves inefficient and sometimes difficult processes that cost practices time and money, and often create stress and add pressure on physicians.

Increasing documentation requirements from Medicare and commercial payers have also added to physicians' administrative workload. Dated documentation requirements for Evaluation and Management (E/M) services are considered to be over burdensome and no longer aligned with the modern practice of medicine.[25] A 2013 survey indicated 92 percent of medical residents and fellows reported that documentation requirements were excessive.[26] Clinical documentation requirements have increased over time with the mandated use of EHRs, increased quality reporting and other factors,[27] contributing significantly to the administrative overload.

Regulatory requirements can be an additional source of time-consuming tasks that lead to stress and burnout for physicians. The QPP, a new Medicare physician payment system created by MACRA, comprises two tracks through which physicians and practices can participate: the Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs). Participation in either track of the QPP requires specific uses of EHRs as well as recording, tracking and submitting quality and clinical practice improvement data to CMS in order to receive payment incentives and/or avoid payment penalties. While the changes implemented through the QPP represent an improvement over legacy Medicare pay-for-reporting programs, time and education are needed for physicians to feel prepared and comfortable conforming to new requirements. A recent KPMG-AMA survey demonstrated that more than half of physicians are just somewhat knowledgeable about MACRA or QPP, and 41 percent have heard of MACRA or QPP but do not consider themselves knowledgeable.[28] Additionally, 90 percent of the physicians participating in MIPS felt that the requirements are slightly or very burdensome, and the time required to report the required metrics is the most significant challenge.[28]

In addition to the strains created by tasks involved in day to day business of medicine, there are other processes that require time away from patient care and/or add stressful tasks to the physician workload. MOC, which is in some states a prerequisite for credentialing or insurance network participation, involves costly fees and lengthy tests which more than 80 percent of physicians feel are over burdensome.[29] After years of advocating for change, physician groups, including the AMA, have prompted the American Board of Internal Medicine to relax its MOC requirements with the introduction of simplified open-book exams starting in 2018.[30] There is also evidence that requests for information about mental illness and medical conditions on state medical license applications may deter physicians from seeking needed health care, for fear of the impact on licensure or employment.[31] Leaving mental health issues or conditions untreated can result in further exacerbation of stress or depression that can lead to burnout, and can even lead to other illnesses and effects on job stability.[32]

The AMA has dedicated numerous resources to reduce administrative burdens that cause stress and excessive workloads, assist physicians in navigating complex processes that come with new regulations, and combat the burnout epidemic.

Through ongoing advocacy, the AMA works to address administrative burdens such as utilization management programs, prior authorization requirements, complex claim processes and other nonclinical activities that contribute to increased complexity and expense for physicians in practice. In addition, the AMA provides practical interpretation of legislation and regulations to help the practicing physician understand changes that may impact their practice. These are done via the AMA website, webinars, podcasts, STEPS Forward™ modules and live presentations to organized medicine. The AMA sections' governing councils also continue their respective efforts to provide strategies and recommendations to address payment reform, prior authorization, and other issues that affect the practice of medicine.

In addition to advocacy, the AMA is working to provide useful tools for physicians to learn about and navigate new payment models, including MIPS and APMs. The "Navigating the Payment Process" topic page within the AMA website is a continuously growing wealth of information, resources and actionable tools to assist physicians in these complex administrative functions.

For physicians, residents, medical students and practices, AMA offers free access to its STEPS Forward online educational platform. The modules in the STEPS Forward platform provide simple, meaningful step-based strategies for addressing stress and burnout. Relevant modules include "Preventing Physician Distress and Suicide," "Physician Wellness: Preventing Resident and Fellow Burnout," "Improving Physician Resiliency," "Preventing Physician Burnout," and "Creating the Organizational Foundation for Joy in Medicine™." Through the STEPS Forward site the AMA also provides access to the Mini-Z Burnout Survey, which enables organizational leaders, including residency program administrators, to periodically measure burnout levels among their staff and residents. The Mini-Z survey also affords the AMA an opportunity to create a robust data set to aid in the understanding of unique drivers of burnout and inform the AMA's continued work in this area.

The Professional Satisfaction and Practice Sustainability strategy group, one of the AMA's three strategic focus areas, continues to study and publish findings on burnout, its causes and effects, and strategies for addressing it.[22, 23, 33-39] Currently in progress is a collaboration with Stanford Medicine WellMD Center and the Mayo Clinic to produce a follow-up study to the 2011 and 2014 burnout and satisfaction research. The AMA has collaborated with the Canadian and British Medical Associations for decades to co-host the International Conference on Physician Health, and will continue this long-standing partnership in 2018. The AMA will also co-host with Stanford University School of Medicine and the Mayo Clinic the second American Conference on Physician Health in 2019. Both of these highly attended conferences offer programming to educate and engage physicians, residents and medical students in organizational and individual level solutions to promote and improve physician and trainee health and wellness.

The AMA's Accelerating Change in Medical Education strategy group is dedicated to fostering innovations in medical education that will create a learning environment and culture that ensures the psychological, emotional and physical wellbeing of medical students and residents. One example of the programming being put forth by this initiative is an online webinar that discusses national and local efforts to prevent burnout and promote wellness throughout the physician education continuum. The AMA also hosts a "Succeeding in Medical School" topic hub in which a variety of relevant resources cover issues such as easing stressors, managing medical school stress, and alleviating anxiety over exams.

CONCLUSION

The AMA recognizes the significant stressors and burdens that face medical students, residents and physicians throughout their careers, and the effects those tolls have on physician well-being and patient care. It is part of AMA's strategic focus to help physicians create thriving, sustainable practices and improve professional satisfaction with the practice of medicine. The AMA is demonstrably committed to this work and continues to study the prevalence and severity of burnout among physicians and trainees, identify factors that contribute to burnout, and develop solutions to address the issue. The AMA will also persist in its efforts to advocate for better legislation and regulations that do not overburden physicians with excessive administrative tasks and requirements.

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37. ELIMINATE THE REQUIREMENT OF H&P UPDATE
(RESOLUTION 710-A-16)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 710-A-16
REMAINDER OF REPORT FILED
See Policy H-160.895

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Board of Trustees (BOT) Report 18-A-17, "Eliminate the Requirement of H&P Update," was referred for report back at the 2018 Annual Meeting. BOT Report 18-A-17 concerned Resolution 710-A-16, "Eliminate the Requirement of H&P Update," which was referred during the 2016 Annual Meeting. Resolution 710-A-16, sponsored by Ohio Delegation, asked our American Medical Association (AMA) to work to change the Centers for Medicare & Medicaid Services' (CMS) Medicare Conditions of Participation (COP) regulations governing the medical history and physician examination update and documentation requirements (H&P update) prior to surgery or a procedure as follows:

Change regulation 42 C.F.R. section 482.24 (c)(4)(i)(B) to read as follows:

When the medical history and physical examination are completed within thirty days before admission or registration, documentation of an updated examination of the patient must be placed in the patient's medical record within twenty-four hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, only if any changes have occurred in the patient's condition.

Change regulation 42 C.F.R. section 482.51(b)(1)(ii) to read as follows:

When the medical history and physical examination are completed within thirty days prior to admission or registration, an updated examination of the patient must be completed and documented within twenty-four hours of admission or registration only if any changes have occurred in the patient's condition.

At the 2016 Annual Meeting, the HOD supported referral of Resolution 710-A-16 because testimony was mixed and the topic involved clinical, legal, and regulatory considerations. The sponsoring delegation testified that physicians should not have to document "no change" in the patient's H&P update on the day of a procedure or surgery. Other testimony emphasized the importance of documenting updates on the date of surgery and potential risks associated with not documenting changes or "no change" in the patient's condition. One speaker noted that H&P update requirements are not particularly burdensome to physicians. Additional speakers noted the complexity of the issues brought up by Resolution 710-A-16, and that patient needs may differ depending on their health and the procedures they are receiving.

BOT Report 18-A-17 recommended that Resolution 710-A-16 be adopted and noted that the H&P update requirement constitutes a compliance burden for physicians when a patient's health status remains unchanged without a direct clinical benefit. It is reasonable to create a regulatory presumption that the H&P update was performed and remained unchanged if documentation to the contrary is not provided. Qualified individuals with privileges would still have to document when changes have occurred; thereby, safeguarding patient safety and ensuring a basic standard of care is met.

At the 2017 Annual Meeting, the HOD supported referral of BOT Report 18-A-17 because testimony was mixed—but mostly negative. While there was some support for the report's recommendations, a preponderance of the testimony expressed concerns about adopting Resolution 710-A-16. Testimony emphasized the importance of documenting the H&P updates on the day of a procedure or surgery and the potential risks associated with not documenting these encounters. A speaker noted that failing to document the H&P update would be a violation of conventional risk management practices. Others questioned whether the documentation is in fact an H&P update. The importance of pre-operative visits was also emphasized, and it was noted that patients can change their minds about surgeries at the last minute. Because a preponderance of the testimony was in opposition to the report's recommendation, the Reference Committee believed clarification was needed and recommended that it be referred for decision at the 2018 Annual Meeting.

AMA POLICY

The AMA does not have policy that is directly applicable to whether the documentation requirements of the H&P update are appropriate or not. There is, however, policy that is germane to the issue of medical record authentication in the context of physical examinations, though it provides for a streamlined approach—namely a single signature to authenticate a host of services and procedures provided to a patient. Policy H-225.965, "Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record," reads:

The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.

DISCUSSION

Although H&P update requirements constitute a small administrative burden for physicians when a patient's health status remains unchanged, it is good medical practice and risk management. Also, the current regulatory requirement

was issued as an alternative to a more onerous proposed Medicare requirement that would have hindered patient access to care. (See discussion below.) Furthermore, if there is a poor patient outcome, the H&P update provides compelling evidence that an H&P update (even if there is no change in status) was performed and demonstrates compliance with Medicare COP during an investigation.

In order to participate in the Medicare program, health care providers, such as hospitals, must comply with statutory and regulatory COP requirements. The COP are established through notice and comment rulemaking and represent Medicare's minimum health and safety standards. CMS ensures compliance by conducting (or contracting with state health survey agencies to conduct) scheduled or unscheduled investigations (called surveys) to assess compliance. These surveys will include sampling and review of patient records, standard operating procedures, and associated documentation among other survey activities. Alternatively, hospitals may receive certification to participate in the Medicare program by obtaining accreditation from an accrediting body approved by CMS. Accredited institutions are deemed to meet all of the Medicare COP, with some exceptions. Currently, CMS-approved accrediting bodies for hospitals include, but are not limited to, The Joint Commission and the American Osteopathic Association.

In 2006, CMS issued a final rule, titled *The Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations*. The final rule incorporated requested changes that reduced compliance burdens on patients and physicians. Among other things, the final rule expanded the timeframe for completion of the pre-operative H&P to 30 days and expanded the number of permissible professional categories of individuals who may perform the history and physical examination. The final rule also required that all orders, including verbal orders, be dated, timed, and authenticated by a practitioner responsible for the care of the patient. The proposed rule would have required the pre-operative H&P to be completed only by a physician credentialed by the medical staff at the admitting hospital. For many patients, this would have excluded their primary care provider, who may not be credentialed and privileged at the admitting hospital. CMS struck this requirement and put an alternative requirement in place as outlined below:

> If a patient's H&P is completed before admission to the hospital, an updated examination must be completed and documented in the patient's medical record within 24 hours after admission, but before a surgical procedure. This update to the H&P would be completed after the patient is admitted to the hospital by a physician, oromaxillofacial surgeon or other qualified individual who has been granted these privileges by the medical staff in accordance with State law. Therefore, if the H&P was completed by the patient's primary care provider, the H&P would be reviewed, the patient would be examined, and the H&P would be updated by an individual who has been credentialed and privileged by the medical staff to conduct an H&P. If upon review, the H&P done before admission is found to be incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P, and conduct and document a new H&P within 24 hours after admission, but before a surgical procedure. The practitioner completing the update is responsible for ensuring that the H&P documented in the medical record is complete and accurate.

CONCLUSION

The H&P update documentation requirements are utilized to ensure that the physician performing the procedure or surgery attests that the H&P was performed properly, is accurate and up-to-date, and that the patient is deemed to be safe for the planned surgery or procedure. Seeking to reverse this regulatory concession would invite a return to the original proposed rule that the pre-operative H&P must be performed by a physician credentialed and privileged in the admitting hospital. In addition, physicians would no longer have the legal benefit that extends to physicians who are able to demonstrate through documentation that they complied with Medicare COP and accepted standards of care.

RECOMMENDATION

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 710-A-16 and the remainder of the report be filed.

> That our AMA work with the Centers for Medicare and Medicaid Services to redefine the requirement that an update to a history and physical within twenty-four hours of a surgery/procedure to mean that the physician

and/or non-physician provider has reviewed pertinent data and the original documented history and physical is sufficient information to determine that it is safe to proceed with the planned surgery or procedure.

38. TIMELY REFERRAL TO PAIN MANAGEMENT SPECIALIST
(RESOLUTION 714-A-17)

Reference committee hearing: see report of Reference Committee E.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
                   IN LIEU OF RESOLUTION 714-A-17
                   REMAINDER OF REPORT FILED**
                   See Policy H-185.931

INTRODUCTION

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 714-A-17, "Timely Referral to Pain Management Specialist," for report back at the 2018 Annual Meeting. This resolution was introduced by the Michigan Delegation and asked that:

> Our American Medical Association (AMA) urge the Centers for Medicare & Medicaid Services (CMS) and the Medicare Contractor Advisory Committee to endorse and adopt evidence-based clinical practice guidelines on the management and treatment of pain including but not limited to timely and appropriate referral to pain management specialists.

During the hearing on this resolution, Reference Committee G heard mixed testimony. The majority of testimony on Resolution 714 opposed mandating that physicians should refer patients to pain management specialists. Testimony also noted the lack of access to pain management specialists in many communities, in addition to long waiting times to see pain specialists, making timely referrals to see these specialists problematic. This report discusses whether the AMA should urge CMS to adopt clinical practice guidelines on the management and treatment of pain.

BACKGROUND

Existing AMA Policies

The AMA currently has numerous policies on pain management, including Policies H-185.931, "Coverage for Chronic Pain Management," H-410.958, "Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers," H-410.950, "Pain Management," D-120.976, "Pain Management," and D-160.981, "Promotion of Better Pain Care."

These policies note AMA's support for health insurance coverage that gives patients access to the full range of evidence-based chronic pain management. In addition, existing policies state the AMA's support for efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services.

Furthermore, existing AMA policy states that the AMA "will work to ensure that interventional pain management is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence," Policy H-410.958. There is further existing AMA policy which states that the AMA "will support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management," Policy D120.976.

Existing Clinical Practice Guidelines

Numerous clinical practice guidelines exist on the management and treatment of pain, including from the American Academy of Pain Medicine, the American Pain Society, the American College of Emergency Physicians, and American College of Physicians.[1]

DISCUSSION

Clinical Practice Guidelines Developed by Specialties

Resolution 714-A-17 asks the AMA to urge CMS to endorse and adopt evidence-based clinical practice guidelines. However, to do so would be generally inconsistent with current AMA policy. The AMA has historically supported the development of clinical practice guidelines from specialty societies as opposed to CMS or other federal government entities. We believe that specialty societies are better positioned to consult with an array of physicians within a given specialty, and that physicians, rather than CMS, should take the lead on the development of clinical practice guidelines.

In addition, numerous clinical practice guidelines already exist from specialty societies whose physicians handle the management and treatment of pain, including the American Academy of Pain Medicine, the American Pain Society, and the American College of Emergency Physicians. If a physician wishes to refer to clinical practice guidelines on managing and treating pain, there are numerous existing guidelines to consult.

Referral to Pain Management Specialist

Resolution 714-A-17 would call on the federal government to set a standard that physicians should refer patients to pain management specialists. However, AMA policy recognizes that it is not always necessary for patients with pain to be referred to a pain management specialist. In addition, many communities do not have access to pain management specialists or have long waiting times to see pain management specialists, making timely referrals to see these specialists problematic.

Modification of Existing AMA Policy

The adoption of Resolution 714-A-17 would not be consistent with the plethora of existing AMA policy for the reasons stated above. However, the Board of Trustees believes that existing AMA policy should be amended to state more succinctly the AMA's support for efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, with a focus on achieving improvement in function and activities of daily living. Existing policy should also be amended to document the AMA's position that guidance on pain management should be developed by the specialties who manage these conditions.

RECOMMENDATION

The Board of Trustees recommends that Policy H-185.931 be amended by addition and deletion in lieu of Resolution 714-A-17 and the remainder of the report be filed:

Policy H-185.931, "Workforce and Coverage for ~~Chronic~~ Pain Management"

1. <u>Our American Medical Association (AMA) supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.</u>

2. <u>Guidance on pain management for different clinical indications should be developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.</u>

~~1.~~<u>3.</u> Our ~~American Medical Association (AMA)~~ will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.

~~2.~~<u>4.</u> Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based ~~chronic~~ pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.

~~3.~~<u>5.</u> Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, <u>as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics.</u> ~~which have the ability to address the physical, psychological, and medical aspects of the~~

~~patient's condition and presentation and involve patients~~ <u>Patients</u> and their caregivers <u>should be involved</u> in the decision-making process.

6.   <u>Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable.</u>

REFERENCES

1.   For example, see American College of Emergency Physicians, *Optimizing the Treatment of Acute Pain in the Emergency Department*, at https://www.acep.org/Search.aspx?filter=acep&searchtext=pain%20&folderpath=ACEP/Clinical%20and%20Practice%20Management/policy%20statements/#sm.0001rldrr218n6d0tq65ngn5ovuzv; American Pain Society, *Clinical Practice Guidelines*, at http://americanpainsociety.org/education/guidelines/overview; the American Academy of Pain Medicine, For the Primary Care Provider: When to Refer to a Pain Specialist, at http://www.painmed.org/files/when-to-refer-a-pain-specialist.pdf; and American College of Physicians, Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians, at https://www.ncbi.nlm.nih.gov/pubmed/28192789.

APPENDIX – Current AMA Policy

Policy H-185.931, "Coverage for Chronic Pain Management"
1. Our American Medical Association will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
2. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
3. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process.

Policy H-410.958, "Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers"
Our AMA: (1) encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that interventional pain management of patients suffering from chronic pain constitutes the practice of medicine; and (2) will work to ensure that interventional pain management is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in pain management and palliative care offered by nursing programs and medical schools in order to demonstrate adherence to current standards in pain management.

Policy H-410.950, "Pain Management"
Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:
Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.
Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include:
1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.
At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.
When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment.

These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.

Policy D-120.976, "Pain Management"
Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain).

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

39. EXPANDING ACCESS TO SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH/SOCIAL DETERMINANTS OF HEALTH IN PAYMENT MODELS (RESOLUTIONS 711-A-17 AND 816-I-17)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: **RECOMMENDATIONS ADOPTED AS FOLLOWS**
IN LIEU OF RESOLUTIONS 711-A-17 AND 816-I-17
REMAINDER OF REPORT FILED
See Policies H-160.896, H-160.909, H-160.919, H-295.874 and D-478.995

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates, Resolution 711-A-17, "Expanding Access to Screening Tools for Social Determinants of Health," was referred for report back. Resolution 711-A-17, which was introduced by the Medical Student Section, asks that the "AMA provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings." At the 2017 Interim Meeting of the House of Delegates, Resolution 816, "Social Determinants in Health in Payment Models," was referred. Resolution 816-I-17, which was

introduced by the American College of Preventive Medicine, asks that the "AMA support payment reform policy proposals that incentivize screening for social determinants of health, as defined by Healthy People 2020, and referral to community support systems."

Resolution 711-A-17 was referred for report back at the 2018 Annual Meeting and Resolution 816-I-17 was referred for report back at the 2018 Interim Meeting. As the referred resolves in each resolution deal with components of a common issue, this report will address the topic as a whole, and present recommendations accordingly.

BACKGROUND

Defining Social Determinants of Health

The World Health Organization defines social determinants of health (SDH) as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." There is a national emphasis in the United States on addressing the SDH by creating "social and physical environments that promote good health for all[1]." There are five key areas of SDH: economic stability; education; social and community context; health and health care; and neighborhood and built environment. Within each of these areas, there are key issues that contribute to the underlying factors of SDH. For example, economic stability examines the impact of employment, food insecurity, housing instability and poverty on a patient's ability to access health care and adhere to treatment.[1]

Recognition of the role SDH play in influencing health outcomes is growing in the health care field, and many physicians are developing strategies to effectively address these conditions which impact every patient. Care models are currently being refined to include selection and implementation of SDH assessment tools; collection of patient-level information related to SDH; creation of workflows to track and address patient needs; and identification of community-based social service resources and tracking referrals.[2]

Evidence-based Screening Tools for Evaluating and Assessing Social Determinants of Health

There presently are several tools available for screening ofrisks or issues related to SDH. Most tools, including those described here, are free to use. The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) Implementation and Action Toolkit, sponsored by the National Association of Community Health Centers, was designed to create and implement a national standardized patient risk assessment protocol to assess and address patients' SDH as well as tools to respond to SDH data.[3] The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. The full question set can be administered in nine minutes or less. A recent study in the *Journal of the American Board of Family Medicine* found that standardizing SDH data collection and presentation in electronic health records (EHRs) could lead to improved patient and population health outcomes in community health centers and other care settings.[4] As of July 26, 2016, the National Association for Community Health Centers reported that only 4 EHR vendors (EPIC, NEXT GEN, eClinical Works, and GE Centricity) currently support the PRAPARE electronic templates.

Another tool, the Patient Centered Assessment Method (PCAM), assesses a patient's lifestyle behaviors, mental well-being, social environment, health literacy, and communication and care coordination needs.[5] This resource contains a section focused on actions that can be taken to address the needs and issues identified in the assessment as well as the level of service coordination needed to ensure referrals can be practically accessed by the patient. A 2015 study found that while PCAM did not impact patient satisfaction or perception of practitioners' empathy, it did increase both the number of onward referrals per referred patient and the proportion of referrals to non-medical services addressing psychological, social, and lifestyle needs.

The American Academy of Family Physicians (AAFP) released an initial screening toolkit for SDH in 2018 to help physicians recognize and respond to various social factors that affect their patients' health.[6] The toolkit includes both a short and long screening tool that includes questions that have been tested, validated, and purposefully assembled to reveal the health hurdles that patients are facing and a sample patient action plan for staff to indicate what types of referrals are needed for patients. As of the time of this report, there are no studies available on the effectiveness of this toolkit. The aforementioned resources indicate there are evidence-based tools to screen for SDH which are accessible and free for physicians to use.

OCHIN, a nonprofit health information and innovation network, integrated SDH screening tools into leading electronic health records (and released an evidence-based set of SDH domain areas for inclusion in EHRs, which was piloted among EPIC users).[7] The integration of the SDH screening tools into the EHR among EPIC user has the potential to reach 25.8 percent of the U.S. physician practice market share. The SDH flowsheet developed by OCHIN provides several means for easily entering patient-reported SDH information that is not already collected in other places in the EHR, such as demographics or social history. Additionally, the data collection tools were designed to be flexible so that anyone on the care team could enter data.

In addition, in 2017 our AMA in collaboration with Lucro launched a platform that streamlines the ability for physicians and health systems to find a number of tools/solutions available on the market, including screening tools for SDH. The platform allows physicians to request information on the clinical validation for a tool, how the tool fits into a workflow/integrates with an EHR, etc., and compares tools to other options available. The Lucro platform is available at app.lucro.com. Also, AMA is currently developing a STEPS Forward™ module to address SDH which will provide physicians with tools, curriculum, and templates to assist in measuring and addressing SDH. The module will also provide strategies for intervention and resources to assist in the understanding of SDH and implementation of tools in practice. Our AMA expects to release this new module in May 2018.

Incentives for Use of Evidence-Based Social Determinants of Health Screening Tools and Interventions in Clinical Settings

Public payers, such as Medicaid and Medicare, may provide financial incentives to encourage providers to address the social needs of their patients as well as the social conditions in the communities in which they serve. For example, Medicare's Comprehensive Primary Care Plus (CPC+) model, which is a multi-payer, patient-centered primary care medical home, requires participating clinicians to risk-stratify patients based on health-related social needs and other factors. CPC+ provides extra payments to participating practices to cover non-face-to-face services and allows practices to provide intensive care management and other supportive services to patients with complex needs. According to the 2016 Kaiser Family Foundation 50-state Medicaid budget survey, states are using managed care and alternative payment models to improve quality and to help screen for social factors impacting health outcomes. In Fiscal Year 2016, 26 states reported requiring or encouraging managed care organizations to screen for social needs and provide referrals to services, and four states intended to do so in FY 2017.[8]

AMA POLICY

AMA Policy H-160.909, "Poverty Screening as a Clinical Tool for Improving Health Outcomes," encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.

Policy H-160.919, "Principles of the Patient-Centered Medical Home," outlines the principles of the patient-centered medical home (PCMH), one which states that care is to be coordinated and/or integrated across all elements of the complex health care system and the patient's community. This policy further calls for care that is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The policy asserts that the payment structure should appropriately recognize the added value of the PCMH and pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources, and recognize case mix differences in the patient population being treated within the practice.

Policy D-478.995, "National Health Information Technology," directs AMA advocacy in the health IT arena, and specifically calls for continued research and physician education on EHR design and features that can improve health care quality, safety and efficiency.

Policy H-295.874, "Educating Medical Students in the Social Determinants of Health and Cultural Competence," states that our AMA: (1) Supports efforts designed to integrate training in SDH and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care; (2) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of SDH and cultural competence in the

undergraduate medical school curriculum; and (3) Recommends studying the integration of SDH and cultural competence training in graduate and continuing medical education and publicizing successful models.

DISCUSSION

Screening for SDH does not need to be administered by a physician and it can be performed upon check in, or while rooming the patient, so that it does not disrupt the flow of the visit while promoting more comprehensive care. Screenings are most frequently conducted by the other members of the care team such as the registration staff, medical assistants, and care coordinators. Having knowledge about a patient's SDH may help physicians understand barriers patients face in adhering to recommended treatments. For example, if a patient screens food insecure, they may not be able to fill prescriptions or take medication as recommended. Knowing such information in advance, may help physicians engage in collaborative discussions with their patients regarding treatment options that make sense for the patient.

Key principles for expanding access to screening tools for SDH are reflected in existing AMA policy. Several tools for screening are publicly available for physician and care team use and have been incorporated into some EHR products. Furthermore, our AMA is developing a related STEPS Forward module to increase physician awareness and understanding of SDH. Also, national initiatives exist to incentivize providers for screening for SDH. Based on these factors, the Board of Trustees believes existing policy and actions regarding access of screening tool are sufficient. However, AMA Policy D-478.995, "National Health Information Technology," could be amended by addition to urge EHR vendors to adopt SDH templates without adding further cost for physicians.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 711-A-17 and 816-I-17 and the remainder of the report be filed.

1. That the following policies be reaffirmed:

    - H-160.909, "Poverty Screening as a Clinical Tool for Improving Health Outcomes"
    - H-160.919, "Principles of the Patient-Centered Medical Home"
    - H-295.874, "Educating Medical Students in the Social Determinants of Health and Cultural Competence"

2. That Policy D-478.995, "National Health Information Technology," be amended by addition to read as follows:

    1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
    2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for ~~more~~ continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
    3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
    4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity

and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

3. That our AMA support reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

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40. MEDICARE COVERAGE OF SERVICES PROVIDED BY PROCTORED MEDICAL STUDENTS (RESOLUTION 812-I-17)

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATION ADOPTED
**   RESOLUTION 812-I-17 NOT ADOPTED**
**   REMAINDER OF REPORT FILED**
*   See Policy TBD*

At the 2017 Interim Meeting, the House of Delegates (HOD) referred Resolution 812-I-17, "Medicare Coverage of Services Provided by Proctored Medical Students," for report back at the 2018 Annual Meeting. This resolution was introduced by the Michigan Delegation and asked that:

> Our American Medical Association (AMA) amend Policy H-390.999, "Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries," by addition as follows:
>
> > When a physician assumes responsibility for the services rendered to a patient by a medical student, a resident, or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision; and
> >
> > Our AMA work with the Centers for Medicare & Medicaid Services (CMS) to require coverage of medical services provided by medical students while under the physician's personal observation, direction, and supervision.

This report provides background on payments to physicians in teaching settings and medical students providing care.

BACKGROUND

In the *Guidelines for Teaching Physicians, Interns, and Residents,* CMS defines a student as an individual who participates in an accredited educational program (for example, medical school) that is not an approved Graduate Medical Education (GME) program and who is not considered an intern or a resident.[1] Medicare does not pay for any services furnished by these individuals. Specifically, CMS only reimburses for services provided by licensed physicians, which medical students are not.

In the *Guidelines*, CMS also states that "any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or resident in a service that meets teaching physician billing requirements."[2] However, CMS has clarified that, although under Medicare services by students are not billable, teaching physicians can involve students in services they perform, and to the extent that the medical student is involved in procedures under the personal supervision of a teaching physician who is performing the service, there is no prohibition against the teaching physician billing for these services.[3] Any contribution and participation of a student in the performance of a billable service must be performed in the physical presence of a teaching physician or resident in service that meets teaching physician billing requirements.

During the reference committee hearing, there was testimony from the Council on Medical Education calling for Resolution 812 not to be adopted because of current CMS guidelines on teaching physicians, and the current restrictions on reimbursing only for services provided by licensed physicians.

DISCUSSION

In a teaching scenario, the teaching or supervising physician is making all of the medical decisions and is supervising any procedures performed by the medical student. Therefore, it is logical that the teaching or supervising physician will bill and be paid for the procedures or services. For billing purposes, the physician must also be the individual to document the procedure, including the medical student's participation.

In addition, Resolution 812-I-17 raises concerns because it would allow non-licensed medical students to bill for services. While the AMA has policy supporting payment for services rendered to a patient by a resident or an intern, who are licensed, it would be unprecedented to include medical students in this policy and advocate that CMS reimburse a non-licensed clinician.

Resolution 812-I-17 also raises liability concerns because it would allow physicians to bill for services performed solely by medical students. In order to ensure physicians are not exposed to increased liability, the AMA should not advocate that physicians be responsible for procedures that were performed by medical students who were not overseen by a teaching or supervising physician.

Finally, adoption of Resolution 812-A-17 could blur the line between the learning environment, where medical students pay tuition to cover the costs of being provided an education to become a physician, and the practice environment, where licensed physicians are compensated for providing their time and expertise educating medical students, as well as for treating patients. The Board's view is that these roles should remain separate.

RECOMMENDATION

The Board of Trustees recommends that Resolution 812-I-17 not be adopted and the remainder of the report be filed.

REFERENCES

1. Guidelines for Teaching Physicians, Interns, and Residents. Medicare Learning Network. March 2017. Viewed on January 24, 2018 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf.
2. Id.
3. University of Washington Medicine Guidance Document. Billing for Procedures when Medical Students Participate. Viewed on January 25, 2018 at http://depts.washington.edu/comply/docs/MedStudentsAdvisory.pdf.

41. AUGMENTED INTELLIGENCE (AI) IN HEALTH CARE

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 205
REMAINDER OF REPORT FILED
PROPOSED AMENDMENT REFERRED
See Policy H-480.940

A component of the American Medical Association's (AMA) strategic work in 2018 and beyond is to provide the physician perspective across health care technology sectors by promoting improved usability of and productive access to data used in medical decision making as well as respect for the patient-physician relationship. As our AMA implements this component of its strategic plan, the Board of Trustees has observed a rapidly growing interest in augmented intelligence (AI) technology in health care. In 2018, the AMA Council on Long Range Planning and Development (CLRPD) provided the Board with a primer on the history, definitions and components, and the status of AI in health care that offered a high-level look at this rapidly evolving area and its potential to dramatically impact medicine. The AMA Council on Legislation (COL) and CLRPD have observed increased interest in AI by Congress, federal agencies, and other health care stakeholders. To form a clearer understanding of the expected impact of AI technologies for patients and physicians, as well as key stakeholders who are influencing legislation and regulation in this area, over the past 18 months the COL has met with physician experts immersed in the development and clinical integration of various health care AI technologies.

Both Councils have highlighted to the Board that current AMA policy does not specifically address AI. The Board determined that this gap in policy puts our AMA at a strategic disadvantage in the public debate on health care AI, and therefore strongly believes it is important for our AMA to adopt a base-level of policy on health care AI to guide AMA's engagement with a broad cross-section of stakeholders and policymakers in order to ensure that the perspective of physicians in various practice settings informs and influences the dialogue as this technology develops.

WHAT IS HEALTH CARE AI?

Computational methods and techniques for data analysis have been evolving for decades [1,2]. A number of these methods have come to be known collectively as "artificial intelligence." Artificial intelligence constitutes a host of computational methods that produce systems that perform tasks normally requiring human intelligence. These computational methods include, but are not limited to, machine image recognition, natural language processing, and machine learning. However, in health care a more appropriate term is "augmented intelligence," reflecting the enhanced capabilities of human clinical decision making when coupled with these computational methods and systems.

In December 2017, Senators Maria Cantwell (D-WA), Todd C. Young (R-IN), and Edward Markey (D-MA) and U.S. Representatives John Delaney (D-MD) and Pete Olson (R-TX) introduced S. 2217/H.R. 4625, "Fundamentally Understanding the Usability and Realistic Evolution (FUTURE) of Artificial Intelligence Act of 2017." The legislation defines "general AI" as computational methods that produce systems that exhibit intelligent behavior at least as advanced as a human across the range of cognitive, emotional, and social behaviors. In contrast, the bill defines the term "narrow AI" as computational methods that address specific application areas, such as playing strategic games, language translation, self-driving vehicles, and image recognition. Thus, these AI methods and tools for the foreseeable future are better characterized as narrow AI that augments human intelligence (augmented intelligence).

At a February 2018 U.S. House of Representatives Government Oversight Committee Subcommittee on Information Technology hearing, three national experts testified that general AI is decades away and agreed AI is best characterized as augmented intelligence. Consistent with the foregoing, in response to a 2016 Request for Information on Artificial Intelligence issued by the White House Office of Science and Technology Policy, IBM stated that it is "guided by the term 'augmented intelligence' rather than 'artificial intelligence'." IBM noted further, "It is the critical difference between systems that enhance and scale human expertise rather than those that attempt to replicate all of human intelligence." [3]

Software algorithms developed using these evolving methods and techniques, coupled with proliferating sources of data (datasets) pertinent to health and medicine, offer the promise of new and more powerful ways to augment human intelligence and expertise in health care.

The American College of Radiology (ACR), which has been at the leading edge of health care AI, addressed its promise in comments to the White House Office of Science and Technology Policy in 2016:

> AI could offer various benefits to medical imaging in the future, including augmenting the capabilities of radiologists to enhance their efficiency and accuracy, as well as reducing costs by improving the appropriateness and cost-effectiveness of medical imaging utilization. The use of AI and machine learning in health care in general could be best applied to the areas of precision medicine, predictive analytics, and outcomes assessments. AI can streamline health care workflow and improve triage of patients (especially in acute care settings), reduce clinician fatigue, and increase the efficiency and efficacy of training. Moreover, shortages of medical experts to meet the needs of vulnerable and underserved populations in domestic and international settings could potentially be relieved, in part, by AI [4].

Prime AI applications include clinical decision support, patient monitoring and coaching, automated devices to assist in surgery or patient care, and management of health care systems [5]. AI in health care holds out the prospect of improving physicians' ability to establish prognosis [6], as well as the accuracy and speed of diagnosis [6,7,8], enabling population-level insights to directly inform the care of individual patients [9], and predicting patient response to interventions [10]. The number of empirical studies of AI applications in medicine is growing rapidly [2].

WHAT'S NEXT IN HEALTH CARE AI?

Commercial entities, including IBM, Google, and others, are driving rapid evolution in AI across the board. In health care, the next three to five years will be marked by efforts to scale AI options involving patient-centered wearables that support clinical care, improved tools for diagnosis and physician training, and health system

initiatives to improve patient care and clinical decision support [11]. The following are early examples of such efforts.

Wearable AI

Wearable monitoring devices that can transmit patient data are evolving rapidly. For example, one company has developed the Cardiogram application which is designed to work with the built-in infrared heart rate sensor of the Apple Watch to detect hypertension and sleep apnea. In a study carried out with the University of California–San Francisco that involved over 6,000 patients, the application and its machine learning system, DeepHeart, was able to detect hypertension and sleep apnea with 82 percent and 90 percent accuracy, respectively [12]. Rapid innovation is expected on this front propelled by coverage of payers, including Medicare, of remote patient monitoring and management.

New Tools for Diagnosis and Physician Training

The utilization of machine learning algorithms to enhance clinical decision making is increasing, but emerging systems take such support a step further. For example, the Human Diagnosis Project (Human Dx), organized as a tandem 501(c)(3) nonprofit and public benefit corporation, and created with and led by the medical community, allows attending physicians to ask for assistance on difficult medical cases from an online community of physicians all over the world. Responses from the medical community are combined with help from machine learning to create a synthesized collective assessment for each case. This collective insight is designed to augment clinical decision making with machine intelligence, providing useful information to physicians and patients who may not otherwise have access to specialist expertise. Human Dx also provides a platform for medical education through its Global Morning Report teaching cases. Today, residents from over 40 percent of U.S. internal medicine residency programs have access to these cases. Human Dx vets the quality of responses by comparing how physicians solve reference training cases in order to calculate a quantitative measure of reasoning called Clinical Quotient, which is now being vetted in conjunction with the Johns Hopkins School of Medicine.

Health Systems and Data Analytics

Applying AI to health system data to improve care is another area of rapid evolution. The University of Pittsburgh Medical Center (UPMC) has launched a system-wide effort to reduce hospital readmissions and enhance clinical decision making while a patient is receiving care. UPMC has applied machine learning to claims data to predict a patient's risk of readmission before the patient arrives. A second algorithm uses laboratory and clinical metrics extracted from clinical records to update the risk prediction every 15 minutes over the course of the patient's admission. Before discharge, if the risk prediction's two models are in conflict, UPMC uses unsupervised machine learning to come up with a set of rules that dictate which model takes precedence to inform clinician discharge decisions [13].

These three relatively nascent efforts are designed to scale, but will require significant additional research and real world testing. However, they illustrate the types of initiatives beyond condition-specific efforts to enhance clinical decision support that could produce significant improvements in health care. Notably, these efforts have active engagement and support of clinicians and seek to address medical challenges and problems identified by clinicians.

FEDERAL ENGAGEMENT WITH AI

AI has surfaced as a public policy issue at the federal level in a relatively short period of time. In 2016, the White House Office of Science and Technology hosted several public meetings on a range of public policy issues addressing AI along with a public request for information regarding potential policy directions. In Congress, the U.S. Senate Commerce Committee held a hearing titled "The Dawn of Artificial Intelligence" at which the Department Chair for Genomic Medicine at MD Anderson Cancer Center highlighted the clinical applications of AI and discussed policy implications.

Shortly thereafter, the 21st Century Cures Act was passed by Congress and became law in December 2016. The Act included provisions modifying the U.S. Food and Drug Administration's (FDA) oversight of software as a medical device, which has implications for a number of current AI computational methods. The FDA is now actively

evaluating whether a new oversight framework is needed for software as a medical device, a precursor to future oversight models.

The bipartisan "FUTURE of Artificial Intelligence Act," introduced in December 2017, provides for the establishment of a Federal Advisory Committee on the Development and Implementation of Artificial Intelligence. The legislation, if passed, would be the first effort at the federal level to provide a forum for consideration of AI public policy. In 2018, additional legislation has been introduced, and additional congressional hearings held on AI generally, with health care applications receiving particular attention.

ACHIEVING THE PROMISE OF AI IN HEALTH CARE

Fulfilling the promise that "combining machine learning software with the best human clinician 'hardware' will permit delivery of care that outperforms what either can do alone" [14] will require that stakeholders forthrightly address challenges in the design, evaluation, implementation, and oversight of AI systems in health care. In the first instance, stakeholders across the board, not the least among them patients and physicians, must hold realistic expectations for the roles AI tools can and cannot play. Machine learning is only one of the AI computational methods and raises particularly thorny challenges. However, many of the public policy issues (including transparency and intellectual property) and clinical issues that will need to be addressed apply to other AI computational methods that are more common currently, such as natural language processing.

Designing and Evaluating Health Care AI

There is a popular tendency to see AI as, at best, a form of neutral, "objective" decision making, a pristine mathematical process that takes only "the facts" into account, independent of human judgment [15,16,17]. The statistical process of AI specifically seeks to derive a rule or procedure from a body of data that explains that data or is able to predict future data [18]. An AI derived algorithm "is only as good as the data it works with" [19,20]. The data sets on which AI algorithms are trained are created by human agents and are imperfect.

The research, patient care, and insurance records available as training data sets for health care AI can be highly variable, reflecting the different purposes for and processes by which they were created [1,21]. Clinical trials systematically include or exclude participants with certain characteristics; patient charts and insurance records capture information only from those individuals who have access to the health care system and rarely contain information about exposure to environmental toxins. Different data sets focus on different kinds of information to the exclusion of other possible data points, and records capture and preserve information with varying degrees of accuracy.

One of the most significant implications for end users of AI systems is that these systems sets can, invisibly and unintentionally, "reproduce and normalize" the biases of their training data sets [16,17]. In health care, the result can be models that "reflect the conditions only of the fortunate" and yield "an aggregate understanding of health and illness that fundamentally excludes the marginalized" [21] in a way that risks exacerbating existing health disparities. Minority populations can be disadvantaged in the context of AI systems in a second way as well in that "by definition, there is proportionately less data available about minority predictions," while the accuracy of decision making, a proxy for fairness, will be higher for majority groups [17]. Addressing fairness is essential, even if doing so may be costly for developers when it requires them to seek more complex decision rules [17].

Design issues also encompass how a model is evaluated, as well as relationships between the dataset used to train an algorithm and the dataset used to evaluate the algorithm. In the first instance, evaluation criteria must be clinically relevant and evaluation should be representative of how the algorithm will be applied in practice [22]. For example, evaluating a model to predict risk of hospital-acquired infection over the entire course of a patient's admission more accurately predicts how the model would be used and would perform in practice [22]. For predictive models, developers must evaluate "how far in advance the algorithm identifies positive cases." [22] From a clinician's perspective, the critical concern is "predicting events early enough for a relevant intervention to influence care decisions and outcomes." [14] Ensuring that all examples in the training dataset are earlier in time than all examples in the evaluation set helps avoid misleading results by limiting the possibility that training data could otherwise reflect structural changes in hospital population, clinical protocols, electronic health record (EHR) systems, or other factors that occurred over time [22].

Developers also have a responsibility to ensure that their work is transparent and can be reproduced by others [23,24]. Proposed guidelines for essential components of publications reporting development of predictive machine-learning algorithms include not only rationale and objectives, but, importantly, the setting, prediction problem, relevant data, and a description of the building of the predictive model [23]. Authors should also provide information about the final model and its performance, and discuss the clinical implications of the work, its limitations, and unexpected results. Scholars have further recommended creating open repositories for long-term storage, archiving, and access to datasets and code to enable replication of published findings [24].

Furthermore, the AMA's work in the area of EHRs reveals that to be useful and accepted in practice, AI systems need to be developed and evaluated in keeping with best practices in user-centered design [25]. The focus must be on users' needs and usability should be tested by participants who are demographically representative of end users [26].

Health Care AI and Patient Privacy

Commitment to protecting the confidentiality of patient information is central to medicine's professional ethos. In this respect, AI poses a significant challenge where traditional strategies of notification and consent are no longer adequate [18]. Nor are anonymization, deletion of data, or distinguishing metadata sufficiently robust protections in the context of massive complex data sets [18,20] when machine-learning algorithms can identify a record "easily and robustly" from as few as three data points [20].

The ease of re-identification means that, in important respects, traditional expectations for health care privacy are simply no longer attainable. This significantly raises the bar on the task of ensuring the security and integrity of data. Among proposed technical solutions to the dilemma of privacy in large data sets are "blockchain-style" technology to secure data and track access or data auditing systems that allow secure verification of the contents of large data structures, such as those being explored by DeepMind Health in the UK [1]. Researchers at the University of Pennsylvania have explored the creation of publicly sharable simulated datasets that limit possible re-identification as another approach to protecting data privacy [27]. The recent revelation that the data mining firm Cambridge Analytica siphoned private data from 50 million Facebook users to target them for political campaigns raises confidentiality and privacy questions across the spectrum of digital platforms that collect and curate data. While this report establishes policy that underscores the necessity to safeguard individuals' privacy interests and preserve the security and integrity of personal information, the Board recognizes the importance of this issue and will continue to assess our policy as our AMA engages in the public debate and discourse on protecting patient information.

Implementing Health Care AI

The AMA's ongoing engagement with digital health offers insights for understanding, from physicians' perspectives, what is at stake in integrating AI systems into the delivery of health care. The organization's recent survey of 1,300 physicians about barriers to adoption of digital health technologies suggests that physicians are most receptive to digital health tools they believe can be integrated smoothly into their current practice, will improve care, and will enhance patient-physician relationships [28]. Coverage for liability, assurance that data privacy is protected, linkage to their EHR, and billing/reimbursement are key considerations.

Earlier AMA research into physician professional satisfaction found that frustrations with EHRs, especially usability issues, were a major source of dissatisfaction in physicians' professional lives [29]. The findings led the AMA to identify priorities for ensuring usability in EHR systems, including, among other considerations, ensuring that EHRs are designed to meet the cognitive and workflow needs of physicians, that they support team-based care, promote coordination of care, focus on reducing cognitive workload instead of focusing simply on data collection, and incorporate end user feedback into designing and improving EHR systems [25].

AMA policies addressing the use of telemedicine similarly stress the importance of minimizing disruptive effects on patient-physician interactions, ensuring that technologies promote quality of care and safety, and, importantly, establishing mechanisms to monitor the impact of an innovation both to identify and address adverse consequences and to identify and encourage dissemination of outcomes [30,31].

To reap the benefits for patient care, physicians must have the skills to work comfortably with health care AI. Just as working effectively with EHRs is now part of training for medical students and residents [32], educating physicians

to work effectively with AI systems, or more narrowly, the AI algorithms that can inform clinical care decisions, will be critical to the future of AI in health care.

Physicians need to understand AI methods and systems sufficiently to be able to trust an algorithm's predictions—or know how to assess the trustworthiness and value of an algorithm—as a foundation for clinical recommendations. The challenge may be more easily met with advances in "explainable AI," that is, algorithms that can "explain" to users why a particular prediction is made [33,34]. Technology to predict the risk of 30-day readmission for cardiac patients being tested by Boston-based Partners Connected Health provides clinicians with a readmission prediction score and identifies the top factors contributing to that score, providing information that is actionable for clinicians [35].

A LEADERSHIP ROLE FOR AMA

To realize its potential to support improved patient care and health outcomes and enhance physician professional satisfaction, the health care AI enterprise should be informed and guided by the expertise, experience, and leadership of physicians and organized medicine in developing and implementing these tools. Physicians are well positioned to advocate for health care AI solutions that support healthier lifestyles and reduce disease burden, improve access to care, enhance diagnostic accuracy, inform individually tailored treatment plans, and improve patient self-management, adherence, and health outcomes. Physicians are likewise well placed to apply their experience to drive improved design and implementation of health care AI that will strengthen clinicians' relationships with patients; enhance communication among the health care team and between team members, patients, and family members; simplify the coordination of care; minimize administrative burdens; and help the health care team to better deliver care to those patients and populations in greatest need.

As a leading voice in American health care, the AMA is uniquely positioned to help ensure that emerging technologies best serve the nation's patients and physicians. In addition to the work of COL and CLRPD, at the 2017 Interim Meeting all seven AMA councils met jointly with experts from IBM Watson and HumanDx to discuss issues in health care AI. Likewise, the AMA's ongoing engagement with key stakeholders from across the spectrum of clinical care, health care administration, implementation science, and AI product development enables the organization to play a distinctive role in contributing to the overarching vision for health care AI in the U.S.

Through its strategic partnerships and collaborations, the AMA has the capacity to offer the insight that is critical to the development of clinically sound AI systems that will enhance the quality of care and sustain the integrity of patient-physician relationships. The AMA's strong tradition of advocacy positions the organization to promote meaningful oversight of AI as it is integrated into clinical practice.

CONCLUSION

Patients, physicians, and the health care system in the U.S. face enormous challenges in the combined impact of a rapidly aging population, a relative decline in the working population that reduces revenue essential for safety net programs [36], and persistent high costs of care that will strain the nation's ability to support affordable, accessible, high quality care. With the engagement of physicians to identify needs and set priorities for design, development, and implementation, health care AI can offer a transformative set of tools to help patients, physicians, and the nation face these looming challenges. Given the number of stakeholders and policymakers involved in the evolution of AI in health care, it is important that our AMA not only adopt a base level of policy to guide our engagement, but equally continue to refine our policy as an organization to ensure that the perspective of physicians in various practice settings informs and influences the dialogue as this technology develops.

RECOMMENDATIONS

In light of these considerations, your Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

> As a leader in American medicine, our American Medical Association (AMA) has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.

3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
   a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
   b. is transparent;
   c. conforms to leading standards for reproducibility;
   d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
   e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.

4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.

5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

THE FOLLOWING PROPOSED AMENDMENT WAS REFERRED:

Augmented intelligence should be funded as an enhancement to the practice of medicine of the primary care medical home so that patients who really need AI can benefit from the technology and such that AI does not become a requirement that must be incorporated into the care of every patient.

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42. DEMOGRAPHIC REPORT OF THE HOUSE OF DELEGATES AND AMA MEMBERSHIP

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

This informational report, "Demographic Report of the House of Delegates and AMA Membership," is prepared pursuant to Policy G-600.035, "House of Delegates Demographic Report," which states:

> A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

In addition, this report includes information pursuant to Policy G-635.125, "AMA Membership Demographics," which states:

> Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

This document compares the House of Delegates (HOD) with the entire American Medical Association (AMA) membership and with the overall United States physician and medical student population. Medical students are included in all references to the total physician population throughout this report to remain consistent with the bi-annual Council on Long Range Planning and Development report. In addition, residents and fellows endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA-HOD includes both delegates and alternate delegates.

DATA SOURCES

Lists of delegates and alternate delegates are maintained in the Office of House of Delegates Affairs and are based on official rosters provided by the relevant society. The lists used in this report reflect 2017 year-end delegation rosters.

Data on individual demographic characteristics are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all United States and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA membership and the total physician and medical student population are taken from the Masterfile and are based on 2017 year-end information.

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates is less than the 556 allotted at the 2017 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. As such, the total number of delegates and alternate delegates is 985 rather than the 1,112 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 18% of AMA members and approximately 20.6% of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

Table 1 presents basic demographic characteristics of AMA membership and delegates along with corresponding figures for the entire physician and medical student population.

Data on physicians' and students' current activities appear in Table 2. This includes life stage as well as present employment and self-designated specialty.

Table 1. Basic Demographic Characteristics of AMA Members & Delegates, December 2017

2017	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates [1,2]
Total	243,449	1,306,770	985
Mean age (years)[3]	46.9	51.9	55.2
Age distribution (percent)			
Under age 40	51.00%	29.37%	18.07%
40-49 years	9.93%	18.88%	12.59%
50-59 years	10.47%	17.80%	22.03%
60-69 years	10.88%	16.98%	31.78%
70 or more	17.72%	16.98%	15.53%
Gender (percent)			
Male	64.94%	65.55%	71.57%
Female	35.03%	34.36%	28.43%
Unknown	0.03%	0.09%	0.00%
Race/ethnicity (percent)			
White non-Hispanic	54.26%	51.74%	69.24%
Black non-Hispanic	4.61%	4.20%	3.96%
Hispanic	5.41%	5.44%	3.35%
Asian/Asian American	14.74%	15.24%	10.66%

Native American	0.35%	0.26%	0.10%
Other[4]	2.64%	2.52%	1.42%
Unknown	17.99%	20.62%	11.27%
Education (percent)			
US or Canada	83.06%	76.98%	91.88%
IMG	16.94%	23.02%	8.12%

Notes:
1 There were 127 vacancies as of year's end, most of which are unfilled alternate delegate slots.
2 Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
3 Age as of December 31. Mean age is the arithmetic average.
4 Includes other self-reported racial and ethnic groups.

Table 2. Life Stage, Present Employment and Self-Designated Specialty5, December 2017

2017	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates [1,2]
Life Stage (percent)			
Student[6]	23.46%	7.68%	7.21%
Resident[6]	23.61%	10.31%	5.38%
Young (under 40 or first 8 years in practice)	7.44%	15.86%	7.51%
Established (40-64)	22.90%	41.45%	50.36%
Senior (65+)	22.59%	24.71%	29.54%
Present Employment (percent)			
Self-employed solo practice	8.22%	8.96%	13.60%
Two physician practice	1.57%	1.72%	1.93%
Group practice	22.53%	41.14%	39.49%
HMO	0.09%	0.17%	0.71%
Medical school	1.22%	1.68%	4.47%
Non-government hospital	2.33%	2.84%	5.79%
State or local government hospital	4.59%	6.96%	10.46%
US government	1.09%	2.03%	4.06%
Locum Tenens	0.19%	0.21%	0.10%
Retired/Inactive	10.21%	11.44%	5.79%
Resident/Intern/Fellow	23.61%	10.31%	5.38%
Student	23.46%	7.68%	7.21%
Other/Unknown	0.89%	4.87%	1.02%
Specialty (percent)			
Family Medicine	8.61%	11.74%	10.76%
Internal Medicine	19.17%	23.08%	20.20%
Surgery	13.93%	13.49%	21.52%
Pediatrics	4.93%	8.77%	3.65%
OB/GYN	5.22%	4.73%	5.48%
Radiology	3.57%	4.53%	5.08%
Psychiatry	3.92%	5.28%	5.18%
Anesthesiology	3.69%	4.66%	3.86%
Pathology	1.77%	2.24%	2.13%
Other specialty	11.75%	13.82%	14.92%
Students	23.46%	7.68%	7.21%

Notes:
5 See Appendix for a listing of specialty classifications.
6 Students and residents are categorized without regard to age.

APPENDIX - Specialty classification using physician's self-designated specialties.

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology,

	Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

43. AMERICAN PODIATRIC MEDICAL ASSOCIATION REQUEST FOR OFFICIAL OBSERVER STATUS IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATION ADOPTED
**   REMAINDER OF REPORT FILED**
                 See Policy G-600.025

The Board of Trustees has received a request from the American Podiatric Medical Association (APMA) to be considered for Official Observer status in the House of Delegates. The APMA's request has been thoroughly considered using the criteria below (Policy G-600.025, "Official Observers in Our AMA House"):

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both;
2. The organization should be national in scope and have similar goals and concerns about health care issues;
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD; and
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The Board has discussed the APMA's request, and presents the following report.

DISCUSSION

As part of its request, APMA submitted information on how it has met the criteria for Official Observer status, which is summarized below.

Criterion 1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.

APMA has hosted representatives of the AMA at its House of Delegates meeting for over a decade, and invite the AMA representative to its President's Dinner and offer the representative an opportunity to address the APMA House. Dr. Barbe participated in the APMA meeting this year. As a result of these interactions, there have been numerous opportunities to work collaboratively. When he was AMA President and Co-Chair of the Commission to End Healthcare Disparities, Dr. Jeremy Lazarus invited APMA to participate in the Commission. APMA was an active participant, and an APMA representative sat on the Commission's steering committee and co-chaired one of

its committees. APMA was also an active participant in the Physician Consortium for Performance Improvement, and is a current member of the PCPI Foundation.

In addition, APMA participates on the AMA/Specialty Society Relative Value Scale Update Committee (RUC) as part of the Health Care Professionals Advisory Committee (HCPAC) Review Board, and as such regularly collaborates with specialty societies with shared interests (e.g., American College of Surgeons, American College of Radiology, American Academy of Orthopaedic Surgeons). The APMA's RUC liaisons have previously served as HCPAC Chair, on the RUC's Practice Expense Subcommittee, and Research Subcommittee. APMA also actively participates on the CPT HCPAC.

Last, APMA's state component societies collaborate and regularly meet with state medical associations on shared health care issues. One example is the strong collaborative relationship forged between the California Medical Association and its California podiatric counterpart.

Criterion 2. The organization should be national in scope and have similar goals and concerns about health care issues.

The APMA was founded in 1912, and represents a majority of the nearly 18,000 podiatrists in the U.S. APMA has 53 state and territorial component societies. Its mission is to advance and advocate for the specialty of podiatric medicine and surgery for the benefit of its members and the health of the public.

The APMA has similar health reform goals as the AMA, among them universal access and coverage, coverage expansion through a mixture of public and private funding and delivery sources, protection of the patient-physician relationship, support for programs and facilities that serve underserved populations, and tort reform.

The APMA also shares many of the AMA's concerns with regard to payment reform, and has offered the Centers for Medicare and Medicaid Services similar comments regarding such issues, including MIPS and APMs.

Criterion 3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD.

As the national organization representing the majority of US podiatrists, the APMA would bring podiatrists' unique perspectives to the House.

Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The APMA does not represent narrow religious, social, cultural, economic, or regional interests. It has a diverse membership, and its members represent the spectrum of practice types. The APMA works collaboratively with the AMA, state and specialty societies, and the vast majority of its interests align with those of the AMA. Scope of practice issues have occasionally arisen, but on other issues, there has been strong alignment and collaborative work. It should also be noted that podiatry has made significant changes to its educational standards, including the standardization of a three-year hospital based residency in addition to the four-year undergraduate curriculum. Podiatrists also work collaboratively with physicians on a day-to-day basis, particularly within multi-specialty practices.

DISCUSSION

The Board of Trustees appreciates the fact that the APMA has already sent representatives to AMA House of Delegates meetings for over 20 years. As part of its review, the Board made informal inquiries with relevant specialty delegations in the House, and received positive responses with regard to the reception of APMA as an Official Observer. The Board thus believes that the APMA should be recognized as an Official Observer and welcomed to the House in that capacity.

RECOMMENDATION

The Board of Trustees recommends that the American Podiatric Medical Association be admitted as an Official Observer in the House of Delegates, and that the remainder of this report be filed.

Appendix - Official Observers to the House of Delegates

Organization	Year Admitted
Accreditation Association for Ambulatory Health Care	1993
Alliance for Continuing Medical Education	1999
Alliance for Regenerative Medicine	2014
Ambulatory Surgery Center Association	2005
American Academy of Physician Assistants	1994
American Association of Medical Assistants	1994
American Board of Medical Specialties	2014
American Dental Association	1982
American Health Quality Association	1987
American Hospital Association	1992
American Nurses Association	1998
American Public Health Association	1990
Association of periOperative Registered Nurses	2000
Association of State and Territorial Health Officials	1990
Commission on Graduates of Foreign Nursing Schools	1999
Council of Medical Specialty Societies	2008
Educational Commission for Foreign Medical Graduates	2011
Federation of State Medical Boards	2000
Federation of State Physician Health Programs	2006
Medical Group Management Association	1988
National Association of County and City Health Officials	1990
National Commission on Correctional Health Care	2000
National Council of State Boards of Nursing	2000
National Indian Health Board	2013
PIAA	2013
Society for Academic Continuing Medical Education	2003
US Pharmacopeia	1998

44. CMS REIMBURSEMENT GUIDELINES FOR TEACHING PHYSICIAN SUPERVISION (RES. 230-A-17)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: **RECOMMENDATION ADOPTED**
                          RESOLUTION 230-A-17 ADOPTED
                          REMAINDER OF REPORT FILED
                          See Policy H-390.834

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 230-A-17, "CMS Reimbursement Guidelines for Teaching Physician Supervision," for report back at the 2018 Annual Meeting. This resolution was introduced by the Michigan Delegation and asked that:

Our American Medical Association (AMA) recommend that the Centers for Medicare & Medicaid Services (CMS) change its policy to allow reimbursement for minor procedures performed by residents as long as the supervising physician is present for the key portions of the minor procedure.

BACKGROUND

For major surgical procedures, a teaching physician must be physically present during the key portions of the service and must be immediately available to provide the service during the entire procedure.[1] During minor procedures,

which are defined by CMS as lasting five minutes or less, the teaching physician must be physically present during the entire service in order to be reimbursed for the service by Medicare.[2] Specifically, the Medicare Claim Processing Manual states: "For procedures that take only a few minutes (five minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure."[3] The teaching physician is required to document his or her level of participation during the service.

The definition of the critical or key portions of a procedure is defined as "the part or parts of a service that the teaching physician determines are critical or key portions."[4] Currently, many specialty societies define the key portions of relevant major procedures.

DISCUSSION

Major and Minor Procedures Defined by Time

The Board of Trustees agrees that it is not logical to treat major and minor procedures differently based solely on the length of the procedure. Minor procedures are defined as procedures that take five minutes or less to complete. A procedure is determined to be major or minor based on time alone, with no consideration for the intensity or difficulty of performing the procedure. Therefore, many major procedures that are high-risk, intense procedures only require the physician to be present for the key portion of the procedure, whereas the physician is required to be present for the entire procedure for many less intense, minor procedures.

For example, in a dermatology practice, a physician may only be required to be present for certain key portions of a nasal soft tissue reconstruction procedure being performed by a resident, which is a major, high-intensity procedure. However, the teaching physician would be required to be present for the entire wart removal procedure performed by residents, which is defined as a minor procedure. Other minor procedures that would require a physician to be present throughout the entire procedure include 11719, trimming of nondystrophic nails, or 11055, pairing or cutting of benign hyperkeratotic lesion (corn or callus). The Board of Trustees agrees that procedures should be treated the same regardless of the length of time the procedure takes.

Key Portions of Procedures

The definition of the critical or key portions of a procedure is defined as the part or parts of a service that the teaching physician determines are critical or key portions. Currently, many specialty societies define the key portions of relevant major procedures. Therefore, the determination of which portions of a major procedure a physician must be present for are left up to the specialty society, physician, or facility.

The Board agrees that there are some surgeries that may take fewer than five minutes to perform, but which the surgeon would likely need to be present for the entire procedure. For example, 20610 Arthrocentesis, aspiration and/or injection, major joint or bursa without ultrasound guidance, would take fewer than five minutes; however, the teaching physician may need to be present for the entire procedure. On the other hand, there are many minor surgeries where physicians may only need to be present for portions of the procedure, such as a pediatric hearing examination. Therefore, we believe that physicians themselves should determine which portions of a procedure they should be present for, as opposed to relying on the time the procedure takes to complete. Physicians are capable of determining the key or critical portions of both major and minor procedures.

Billing and Documentation Rules for Teaching Physicians

The Board of Trustees notes that there are numerous issues in the current billing and documentation rules for teaching physicians that should be reexamined. Making needed changes to current billing and documentation guidelines for teaching physicians would help reduce physicians' administrative burden, a key focus of the current administration. For example, the U.S. Department of Health and Human Services recently updated the physician billing rules to allow a teaching physician to use medical student documentation, including history, physical exam, and medical student decision making, provided that the physician personally performs or re-performs the physician exam and verifies the student's documentation. The AMA supported these changes, and will continue to seek opportunities to work with other stakeholders to address billing and documentation rules for teaching physicians and teaching facilities.

RECOMMENDATION

The Board of Trustees recommends that Resolution 230-A-17 be adopted and the remainder of this report be filed.

REFERENCES

1. Medicare Claims Processing Manual. Chapter 12, Section 100.1.2.
2. Id.
3. Id.
4. *Teaching Physician FAQ*.

45. LICENSING OF ELECTRONIC HEALTH RECORDS
(RES. 218-A-17)

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 218-A-17
REMAINDER OF REPORT FILED
See Policies D-460.968, D-478.972, D-478.973, D-478.994, D-478.995 and D-478.996

INTRODUCTION

At the 2017 Annual Meeting, the House of Delegates (HOD) referred Resolution 218-A-17, "Licensing of Electronic Health Records," for report back at the 2018 Annual Meeting. This resolution was introduced by the Illinois Delegation and asked that our American Medical Association (AMA):

> Develop model legislation for licensing electronic health records with a focus on ensuring system interoperability.

This report provides background on the lack of usability and interoperability of electronic health records (EHRs). Recent modifications in federal policy aim to improve EHR usability and interoperability by establishing new technical standards, testing protocols, and federal oversight for EHRs and their vendors. This report also outlines AMA-initiated efforts to support regulation and improve EHRs.

BACKGROUND: FEDERAL REQUIREMENTS AND TECHNOLOGICAL BARRIERS
   TO INTEROPERABILITY

The Health Information Technology for Economic and Clinical Health (HITECH) Act, which established both the Meaningful Use (MU) program and the EHR certification process, has radically increased the adoption of EHRs by health care providers since 2009. The HITECH Act's monetary incentives are seen as the primary driver of EHR uptake across the nation. In fact, over 85 percent of physicians use an EHR today.[1] However, the hope and promise of EHRs to provide greater efficiency in health care, improve care coordination, and facilitate data exchange have not materialized.[2]

Federal Requirements: EHR Certification Requirements, Meaningful Use, and Advancing Care Information

The EHR certification process, outlined in HITECH, directs the Office of the National Coordinator for Health Information Technology (ONC) to develop health information technology (health IT) certification criteria, a health IT testing framework, and a certification process. This process specifies what EHR vendors must include in their products to become certified EHR technology (CEHRT). ONC's certification process attempts to ensure that EHRs are interoperable—that is, able to exchange, incorporate, and present information to a physician in a contextual and meaningful manner. However, the act of two computers sending and receiving data, which is what is predominantly tested during the certification process, does not constitute functional interoperability. Unfortunately, vendors narrowly follow the certification requirements, spending the majority of their time meeting Centers for Medicare & Medicaid Services (CMS) and ONC mandates, while allowing for little time and few resources to address physician and patient needs.[3]

Additionally, these certification criteria are only part of a more complex federal process in which EHR vendors participate to sell their products. Other entities, including testing and certifying organizations, play a role in an EHR's path to the marketplace, but their policies and procedures are still governed by federal requirements.

Meanwhile, physicians must use CEHRT to participate in federal reporting programs such as MU and Advancing Care Information (ACI), a component of CMS' Quality Payment Program (QPP).

Despite the MU program's intent to enhance patient access to health information and increase the efficiency and quality of care, many of the program's requirements had the opposite effect.[4] Furthermore, the MU program's requirements continued to drive the design priorities of many EHR vendors, resulting in electronic systems that promote MU regulatory compliance over clinical need, patient well-being, and general innovation.[5] The lack of interoperability among EHRs is a direct result of this misalignment. This can be attributed to the required use of immature technical standards, the federal government's lack of semantic and syntactic testing for interoperability, and MU measures that prioritized measurement and reporting over enabling clinically meaningful data exchange. Though physicians who are eligible for the QPP no longer need to participate in the MU program, many of the MU program's requirements were carried over into ACI—resulting in the continuation of measure-driven design requirements for EHRs.[6]

In sum, while it is widely known that ONC's certification program is primarily designed to validate an EHR's ability to meet MU and ACI requirements, it is also clear that the program has become the high watermark for EHR design. Technology and data exchange standards exist widely across other industries where information seamlessly interoperates.[7] However, health IT continues to lack focus on interoperability and usability as a result of federal priorities and vendor capitulation.

Technological Barriers

Technical barriers also contribute to the process of achieving interoperability. Data stored within one EHR system may not be compatible with another vendor's products, especially if such systems are highly customized or a mismatch exists between the source EHR and the receiving system. For example, many first generation EHRs did not consistently code all patient information stored in their systems, leaving data as free text. In this format, the data are not easily transferred, interpreted, or incorporated in the receiving EHR.[8]

An additional technical challenge is the lack of consensus on how data should be represented. Data that are able to be codified are not necessarily coded in a consistent manner between EHR vendors. For example, a vendor may choose to describe laboratory test orders and results in terms of Logical Observation Identifiers Names and Codes (LOINC) and Systematized Nomenclature of Medicine—Clinical Terms (SNOMED-CT). However, both health IT vendors and health care facilities utilize some discretion when coding medical information, especially when there is a lack of industry consensus or agreement on the coding or terminology that should be used. While there are ONC certification requirements that specify data structure, currently these requirements only address a subset of the entire patient medical record. Medical records that are then coded to this standard often lack medically relevant information that patients and clinicians need.[9] Furthermore, this discrepancy can negatively affect the interoperability between EHRs. The construction of reliable and reusable clinical code sets is essential when re-using EHR data, yet code set definitions are rarely transparent or consistently shared. This lack of methodological standards for the management (construction, sharing, revision, and reuse) of clinical code sets is an additional issue that should be addressed to enable system-to-system interoperability.[10]

The inability of two or more health IT systems to accurately match a patient with their records severely limits interoperability. Patient matching is the ability to link a patient to his or her health records that may be held at multiple locations. Researchers have found match rates as low as 50 percent when matching across health care facilities.[11] Incorrectly linking records to a patient limits the availability of critical data, even within in the same EHR or health system. Exchanging information requires a consistent, reliable mechanism for matching patients to their records. In practice, patient matching is the process of comparing different demographic elements from different health IT systems to determine if they refer to the same patient.[12]

From an interoperability perspective, the ability to match patients and their records efficiently, accurately, and at scale is critical. Patient matching is needed to enable the interoperability of health data for all purposes. Additionally, patient matching also requires careful attention to its effect on patient safety and administrative costs. While numerous recommendations have been issued over the years to tackle different aspects of patient matching, it

is important to recognize that the entire health care system can impact its performance—from data capture at patient registration to the technology and algorithms along the way.[13] At the same time, there has been little transparency about how well current patient matching algorithms perform.

RECENT POLICY AND TECHNICAL EFFORTS TO ADVANCE EHR UTILITY

Both Congress and the recent administrations have made significant advances in policy to address a number of health IT-related issues. Many of the EHR issues addressed in this report originated due to the inability of health IT certification to adapt to changes in technology or physician and patient needs. Health IT certification is a protracted process, often taking between eight and 10 months between proposed and final rules. Health IT developers then need between 18 and 24 months to incorporate federal certification requirements into their products. This cycle can create "new" EHRs that are two and a half years old before they are even available in the market. ONC recognized this and has altered their certification process starting with the 2015 Edition. ONC expects to make smaller, but more frequent certification changes over time.[14]

Congress has also acted to establish much-needed focus and priorities in health IT development, design, testing, and use. The 21st Century Cures Act, discussed in more detail below, articulates Congress' intent to improve health IT development and certification while also establishing forward-looking goals focused on physician need and patient care. Furthermore, Congress has established feedback mechanisms and agency reporting requirements to bolster oversight.

Many of the actions taken by Congress and recent administrations are underway and will be implemented over the next 12 months. However, given the historically intransigent nature of health IT policy, it is expected to take one to two health IT product development cycles before physicians and patients experience the benefits of recent regulatory changes.

ONC's 2015 Edition Health IT Certification

ONC has taken a number of steps to address EHR usability and interoperability concerns through its 2015 Edition health IT certification criteria. The use of 2015 Edition EHRs will most likely be required for participation in the QPP starting in 2019. While the availability of 2015 Edition EHRs is still less than 10 percent of all EHR products on the market, improvements in EHR usability, interoperability, vendor practice transparency, and product safety will become more prevalent in the coming months.[15]

Updated interoperability standards

In a January 2015 letter to ONC, the AMA, along with 36 other medical societies and organizations, made a number of recommendations to improve the functionality of certified EHRs.[16] One key recommendation was for ONC to improve the Consolidated Clinical Document Architecture (C-CDA) guidance and testing to further support data exchange. As identified in our letter, the C-CDA standard allows for vendor optionality in its implementation, yet its use is mandatory in the MU and ACI programs. The offset of prescriptive regulations on use without the necessary oversight on the health IT developer has led to deficiencies in interoperability.[17] However, 2015 Edition Certification identifies new implementation guides and testing. This, coupled with an updated C-CDA version, i.e., R2, will help bolster inter-EHR vendor communication. Furthermore, ONC has increased its testing rigor on standards and system performance.

Increased stringency on EHR safety enhanced design requirements

In our January 2015 letter, the AMA also cited concerns with ONC's certification process for validating whether EHR vendors used proper User Centered Design (UCD) techniques. Experts in human-factors design note that health IT vendors should meet a minimum level of UCD principles. Past versions of health IT certification lacked focus on UCD principles. The AMA recommended ONC increase the robustness of its UCD certification requirements and make testing reports easily accessible and understandable to the physician consumer. 2015 Edition expands the number of certification usability criteria. UCD requirements have been expanded with increased attention on submission requirements and compliance guidance.

Application Programing Interfaces (APIs*)*

In late 2014, the AMA released a new framework for improving EHR usability.[18] This framework, developed with the support of an external advisory committee of noted experts in the field of health IT, outlined eight usability priorities, including the need for EHR modularity and data liquidity. In each instance, APIs were identified as an important contributor to facilitating these goals. ONC's 2015 Edition identifies APIs as one method for providing greater access to patient data in EHRs. ONC's intent is to guide the heath IT market in this direction. Although APIs are nothing new to software development, their use in health IT has been slow to gain traction. With advancements in technical standards, such as Fast Healthcare Interoperability Resources (FHIR), and platforms such as Substitutable Medical Applications & Reusable Technology (SMART), 2015 Edition API requirements are poised to improve EHR usability and interoperability.

"In the field" health IT surveillance

Health IT products are complex and must be thoroughly tested and evaluated during development, deployment, and implementation. Many variables affect the performance of EHRs once they are installed and used by physicians, including customization, aging hardware, external dependencies, and an end user's level of training. This has led to confusion with actual EHR performance. With 2015 Edition, and further expanded by ONC's Enhanced Oversight and Accountability process, the agency recognized these concerns.[19] To increase transparency and ensure physicians have more clarity around their product's capabilities, as part of health IT certification, ONC now requires EHR vendors' marketing materials or contract requirements to comport with actual EHR functionality and capabilities.

ONC's health IT surveillance and maintenance process now includes randomized in-the-field surveillance and the ability for the agency to react to end-user reported concerns with certified product performance. ONC prioritized implementation surveillance on health IT capabilities related to interoperability, patient safety, and privacy and security.

Transparency and disclosure requirements

In addition to the complexity of health IT products, the actual long-term costs of EHRs have not always been clear. Once a product is installed, an EHR vendor typically requires a monthly maintenance fee based on the initial cost of the product. These fees can range from a few thousand to tens of thousands of dollars per month. Additionally, each custom software change or interface needed to meet MU requirements contributes to unexpected costs, which burden physicians and divert resources from patient care.

In 2013 and 2015, the AMA sponsored two RAND studies which found that the lack of resources, both financial and human, needed to manage the increasing level of administrative challenges are a significant issue facing physicians.[20,21] As a result of AMA advocacy, EHR vendors are now required to provide greater transparency related to vendor costs and product capabilities. 2015 Edition requires the disclosure of fees to enable or use all EHR functions.

21st Century Cures Act

With bipartisan support, Congress passed and President Obama signed into law the 21st Century Cures Act (Cures) in December of 2016. Cures covers a wide array of health care issues, most notably focusing on medical research and the approval process for new medications and medical devices. Cures also contains a number of provisions directly impacting the development of health IT. Cures directs the Secretary of the U.S. Department of Health and Human Services (HHS) to identify methods to: reduce physician documentation burden related to EHRs; increase the transparency of EHR usability, security, and functionality; focus efforts on health IT interoperability; establish penalties for data blocking; establish a digital health care provider directory; and directs the Government Accountability Office (GAO) to conduct a study to review patient matching policies and activities.[22]

Reduce regulatory or administrative burdens

Cures directs HHS to establish a goal, develop a strategy, and make recommendations to reduce regulatory or administrative burdens relating to the use of EHRs. Prior to leaving, Secretary Tom Price, MD, directed ONC to coordinate a cross-agency effort to reduce burden. ONC is in the process of establishing working groups and a series

of listening sessions to address EHR usability, electronic quality measurement, documentation burden, and state-based issues. The AMA is actively engaged with ONC and CMS on these initiatives. ONC will release a report to Congress in early 2019.

Transparency reporting on usability, security, and functionality

Cures directs HHS to support and convene stakeholders to develop new reporting criteria for health IT developers. Cures further requires HHS to focus this development on priority uses of health IT, including: the implementation of EHR incentives programs (QPP and MU); quality of care, public health, clinical research, privacy and security, innovation in health IT, patient safety, usability, and individual access. ONC will coordinate this activity. ONC intends to convene stakeholders, review existing standards, and make determinations on future standards and implementation specifications. ONC has signaled their intent to initiate this activity beginning in early 2018.

Interoperability and information blocking

Cures requires, as a condition of health IT certification, developers to meet more stringent interoperability requirements. This includes not engaging in information blocking, which is defined in Cures as preventing, discouraging, or interfering with the access, exchange, or use of information. Furthermore, HHS is directed to initiate rulemaking to identify and define reasonable and necessary activities that do not constitute information blocking. Cures provides HHS' Office of Inspector General (OIG) the authority to investigate and enforce penalties of up to $1 million per violation for developers who block information. In late 2017, the AMA met with the OIG to discuss information blocking. We provided ideas to inform HHS' work on further defining what should and should not be considered as information blocking, specifically as it relates to EHR vendors and physicians. ONC has signaled their intent to release a proposed rule on information blocking in spring 2018.

Provider directory

Cures directs HHS to establish a digital health care provider directory within three years of the Act's enactment. HHS has flexibility in its approach, allowing the agency to utilize an existing provider directory to make digital contact information available. The directory must include information at both the individual health care provider level and health facility or practice level. Congress' intent is to establish a comprehensive index of providers and their associations with health care facilities or practices.

Patient matching report

Cures directs the GAO to conduct a study, within one year of the Act's enactment, to review the policies and activities of ONC and other stakeholders to ensure appropriate patient matching. Congress identified patient matching as a major impediment in the exchange of information. However, since 1999, every HHS appropriations bill has prohibited the agency from allocating resources to the adoption a unique patient identifier. This has long been interpreted to be a de facto ban on any work related to matching patients with their records. However, in addition to the Cures policy review, a recent budget bill passed by Congress and signed into law by President Trump enables HHS to be a technical adviser and assist industry groups' work on patient identification and patient matching.[23] The bill allows ONC and CMS to assist the private sector in developing a "national strategy" to match patients to their health information. Furthermore, the GAO has reached out to the AMA to provide information on the common challenges that physicians face when matching patient records. Our feedback will be included in the GAO's forthcoming patient matching report.

Trusted Exchange Framework

Cures directs ONC to convene stakeholders to develop or support a framework and agreement for the secure exchange of health information between networks, to provide for testing of a voluntary framework and agreement, and publish a list of networks that adopt the agreement. Congress' intent is for a national trust and governance framework that ensures health information is available to patients and physicians and supports the management of patient health and care. ONC released a draft of its framework in January 2018. The draft framework proposes policies, procedures, and technical standards necessary to advance a single "on-ramp" to interoperability. In February 2018, the AMA provided comments to ONC on its draft framework proposal.[24] A final draft of the combined Trusted Exchange Framework and Common Agreement (TEFCA) will be released in late 2018.

DISCUSSION

The AMA is engaged with federal and private sector stakeholders in the implementation of regulatory updates. As discussed in this report, many of the policy changes promoted by Congress and the Administration will take a number of years before improvements to health IT will be realized. However, the AMA is involved in short-, mid-, and long-term efforts to support the development of EHRs and maximize the use of EHRs while minimizing physician burden.

ONC's release of their 2015 Edition Health IT Certification final rule signaled the agency's intent to address a number of concerns and considerations raised by the AMA and other physician organizations.[25] Pursuant to AMA Policy D-478.973, "Principles for Hospital Sponsored Electronic Health Records," the AMA was successful in focusing efforts on increased stringency around EHR usability and interoperability certification and vendor practice transparency. While much of ONC's work is tied to MU and ACI compliance efforts, the AMA has been successful in easing the EHR burden on physicians. In May 2017, AMA senior leadership met the Trump Administration's newly appointed National Coordinator for Health IT. This meeting was a culmination of a multi-month advocacy effort to delay the federal requirement that physicians must adopt, purchase, and upgrade new EHRs. Initially, physicians were expected to migrate from 2014 Edition EHRs to 2015 Edition by January 2018. While many enhancements are expected in 2015 Edition EHRs, at that time few vendors had fully upgraded their systems. Fewer than 70 of the over 3,700 products available had been certified to 2015 Edition. Importantly, the vast majority of the certified 2015 Edition products were from a small number of vendors. Requiring physicians to upgrade to 2015 Edition technology by 2018 would have limited choice by forcing physicians to select a system from approximately one percent of existing products. In addition, physicians may have been driven to switch vendors or utilize a system that was not suitable for their specialty or patient population.[26] Pursuant to AMA Policy D-478.996, "Information Technology Standards and Costs," the AMA was successful in delaying this requirement until 2019.

Recent conversations with health IT vendors have confirmed that 2015 Edition EHR products would not have been available by January 2018. This has resulted in two important developments. First, 2015 Edition products that have already been certified cater primarily to large health systems and hospitals. While only a handful of health systems have adopted 2015 Edition EHRs, their experience with these products has provided much needed real-world feedback. Health IT vendors have since been able to incorporate front-line physician experience into their product design. Second, the delay in adoption has extended vendors' development timeline. EHR vendors have signaled this will enable them to incorporate additional physician requirements and patient care needs into their products.

The AMA participates in multiple meetings and workgroup sessions, providing front-line physician experience back to developers. In addition to supporting usability for physicians, the AMA is also involved in efforts to identify best practices for the implementation of EHRs. Research has shown that increased support is necessary for the successful integration of technology into complex health care environments.[27] The health IT vendor community is expecting to utilize the delay in adoption as an opportunity to study the impact of implementation and customization decisions on physician satisfaction.

Activating a new EHR in a medical practice requires a redesign of clinic workflows. There are many changes that the care team will have to anticipate for a smooth transition to the new electronic record. This involves a multi-disciplinary approach to prepare the new system, ensure privacy and security compliance, design practice workflows, train the care team, and manage the adoption process. Pursuant to AMA Policy D-478.972, "EHR Interoperability," the AMA has created a STEPS Forward™ module designed to assist the practice in adopting and implementing a new EHR.[28] This, along with all STEPS Forward modules, is eligible as an Improvement Activity (IA) in the QPP and Continuing Medical Education (CME) credit.

While the total impact of Cures legislation on interoperability will take many years before it is felt, HHS is actively engaged in implementing provisions focused on the reduction of physician burden. The AMA strongly agrees that burdensome documentation requirements and the associated onerous features of EHRs degrade communication among health care professionals and detract from patient care.

The AMA is committed in working with CMS and ONC, as well as other stakeholders, to identify strategies to ease these pain points. Pursuant to AMA Policy D-478.995, "National Health Information Technology," the AMA recently provided the Administration a high-level framework for dealing with documentation burden associated with EHRs.[29] In it, the AMA identified, as a first step, the need to address documentation guidelines. Current

documentation guidelines require physicians to include a variety of additional information simply to justify code selection as opposed to prioritizing documentation relevant to the patient's current and future treatment. Consequently, EHR vendors use very prescriptive methods to capture "structured" information to align physician services with coding levels—adding unnecessary and extraneous work that detracts from the physician/patient narrative. It should be noted, however, that a comprehensive reform of documentation guidelines will require a multi-year, collaborative effort among clinical, federal, payer, and health IT stakeholders.

Furthermore, the AMA's efforts to improve health IT interoperability and usability go well beyond federal advocacy. While there is a need for new, digital health innovations to improve patient care, it is equally important that innovations are informed by knowledgeable experts who represent a wide-range of clinical specialties. The AMA plays a leading role in the House of Medicine, and is uniquely positioned to bring physicians and innovators together to collaborate on new health care technology and to help ensure proper approaches to interoperability by focusing on the point of care. Through its ongoing work and digital platforms like its Physician Innovation Network, the AMA is providing opportunities for physicians to engage in innovation and share their ideas, expertise, and real-world perspective on the effectiveness of technology in medical practice settings. From revitalizing medical practices to ensuring that digital health is interoperable, usable, and provides high-quality patient care, the AMA is helping physicians navigate and succeed in a continually evolving health care environment.

To support this goal, the AMA established Health2047 in early 2016.[30] Health2047 is a Silicon Valley-based independent, for-profit studio that combines expertise from diverse backgrounds—physicians, engineers, coders, behavioral economists, and psychologists—in development of new solutions. Health2047's mission is to develop, guide, and commercialize disruptive ideas that enhance—at the system level—the practice of health care. By combining the deep knowledge base of the AMA with seasoned innovators in medicine, technology and science, Health2047 is creating products that make health care delivery more effective and efficient. Health 2047 recently launched a new company, Akiri. Its first product, Akiri Switch, is a subscription-based, secure private network that transmits health data through a standardized system.[31] Akiri will bring the first network-as-a-service platform to the health care industry with the intent of: enabling interoperability protected by advanced security protocols; realigning health care technical systems around real-world care needs; improving productivity while reducing physician burden; and facilitating value-based care models.

Another major activity is the AMA's Integrated Health Model Initiative (IHMI).[32] The IHMI is a collaborative effort across health and technology sectors to build a comprehensive data model for organizing and exchanging information to realize semantic and syntactic interoperability and improve patient care. IHMI uses the best available science to incorporate essential data elements around function, state and patient goals to improve patient care. IHMI fills the need for a shared framework for organizing health data, emphasizing patient-centric information, and refining data elements to those most predictive of achieving better outcomes. IHMI supports a continuous learning environment to enable interoperable technology solutions and care models that evolve with real-world use and feedback while facilitating interoperability. As IHMI launches, the focus is currently on:

- Hosting clinical and issue-based communities focused on costly and burdensome areas. This fosters collaborative efforts around common interests and areas of need, such as hypertension management, diabetes prevention, asthma function, and identifying the best available science and practices that define patient-centric care.
- Providing a clinical validation process to determine and apply appropriate clinical frameworks. Participants will provide contributions and feedback online to specify data elements and relationships. Clinical content submissions will go through a validation process to review clinical applicability.
- Specifying a model to encode information in the IHMI data model. Clinical content will enable configurations of the model and reference value sets that can be distributed.

Participation in IHMI is open to all health care and technology stakeholders, and early collaborators include IBM, Cerner, Intermountain Healthcare, American Heart Association (AHA), American Medical Informatics Association (AMIA), as well as a growing list of other individuals and organizations.

While Resolution 218-A-17 highlights issues with EHR interoperability, recent technical, policy, and private-sector efforts are currently underway that are expected to allow for significant improvements in EHR design, testing, certification, and use. Developing model state legislation for the licensure of EHRs will hinder these efforts and could create state-specific barriers to interoperability by establishing different standards among states. This is

especially true given the ease and capability of data to cross-state lines. State licensure could also result in EHR vendors passing additional costs on to the physician. Furthermore, the AMA is already involved in a number of public/private efforts that are in the initial stages of affecting health IT design, usability, and interoperability that are aimed at addressing the concerns raised in Resolution 218-A-17.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 218-A-17 and the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care.

2. That our AMA reaffirm Policies D-460.968, D-478.972, D-478.973, D-478.994, D-478.995, and D-478.996, which broadly direct AMA to continue its leadership in efforts to define and promote standards that facilitate the interoperability of Electronic Health Records (EHRs); to advocate for improvements to EHRs that will enable interoperability and access while not creating additional burdens and usability challenges for physicians; and to advocate for physician flexibility for the adoption and use of certified EHRs and to not financially penalize physicians for using certified EHRs technology that does not meet current standards.

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APPENDIX - AMA Policy

Policy D-478.995, "National Health Information Technology"
(1) Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care; (2) Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems; (3) Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs; (4) Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care

delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery; (5) Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process; (6) Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability; (7) Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability; and (8) Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

Policy D-460.968, "The Precision Medicine Initiative"
(1) Our AMA will work with the Precision Medicine Initiative (PMI) to gather input from physicians to assist in the planning stages of the initiative and to improve awareness and willingness to recruit patients as participants; (2) Our AMA encourages the PMI to develop resources that will assist physicians in understanding the goals of the PMI, how to recruit and enroll patients, and how to best use the research results generated by it; and (3) Our AMA continues to advocate for improvements to electronic health record systems that will enable interoperability and access while not creating additional burdens and usability challenges for physicians.

Policy D-478.994, "Health Information Technology"
(1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; (3) support initiatives to ensure interoperability among all HIT systems; and (4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

Policy D-478.972, "EHR Interoperability"
Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.

Policy D-478.973, "Principles for Hospital Sponsored Electronic Health Records"
(1) Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC); (2) Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production; (3) Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs; and (4) Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

Policy D-478.996, "Information Technology Standards and Costs"
(1) Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems; (2) Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.

46. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES:
FIVE-YEAR REVIEW

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.984

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

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

The following organizations were reviewed for the 2018 Annual Meeting:

Academy of Physicians in Clinical Research
Aerospace Medical Association
American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery, Inc.
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Psychiatry and the Law
American Association for Hand Surgery
American Association of Clinical Urologists, Inc.
American Clinical Neurophysiology Society
American College of Medical Quality
American Society of Addiction Medicine
American Society of Echocardiography
American Society of General Surgeons
American Society of Ophthalmic Plastic and Reconstructive Surgery
GLMA: Health Professionals Advancing LGBT Equality
The Endocrine Society
Spine Intervention Society

The Academy of Physicians in Clinical Research and the American Society of General Surgeons were reviewed at this time because they failed to meet the requirements of the review in 2017.

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

The materials submitted indicate that: Academy of Physicians in Clinical Research, Aerospace Medical Association, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, Inc., American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American College

of Medical Quality, American Society of Addiction Medicine, American Society of Echocardiography, American Society of General Surgeons, American Society of Ophthalmic Plastic and Reconstructive Surgery, GLMA: Health Professionals Advancing LGBT Equality, The Endocrine Society, and Spine Intervention Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations and professional medical interest associations represented in the HOD.

RECOMMENDATION

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

> That the Academy of Physicians in Clinical Research, Aerospace Medical Association, American Academy of Dermatology Association, American Academy of Facial Plastic and Reconstructive Surgery, Inc., American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American College of Medical Quality, American Society of Addiction Medicine, American Society of Echocardiography, American Society of General Surgeons, American Society of Ophthalmic Plastic and Reconstructive Surgery, GLMA: Health Professionals Advancing LGBT Equality, The Endocrine Society and, Spine Intervention Society retain representation in the American Medical Association House of Delegates.

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
Academy of Physicians in Clinical Research	107 of 248 (43%)
Aerospace Medical Association	165 of 670 (25%)
American Academy of Dermatology	3,117 of 13,829 (16%)
American Academy of Facial Plastic and Reconstructive Surgery, Inc.	180 of 826 (22%)
American Academy of Family Physicians	10,132 of 73,415 (14%)
American Academy of Hospice and Palliative Medicine	697 of 3,350 (20%)
American Academy of Neurology	2,934 of 16,925 (17%)
American Academy of Psychiatry and the Law	393 of 1,253 (31%)
American Association for Hand Surgery	200 of 775 (26%)
American Association of Clinical Urologists, Inc.	409 of 1,387 (30%)
American Clinical Neurophysiology Society	103 of 268 (38%)
American College of Medical Quality	179 of 422 (42%)
American Society of Addiction Medicine	821 of 3,914 (21%)
American Society of Echocardiography	1,115 of 6,785 (16%)
American Society of General Surgeons	284 of 811 (35%)
American Society of Ophthalmic Plastic and Reconstructive Surgery	142 of 555 (26%)
GLMA: Health Professionals Advancing LGBT Equality	106 of 317 (33%)
The Endocrine Society	1,016 of 6,915 (15%)
Spine Intervention Society	398 of 1,736 (23%)

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.

REPORT OF THE SPEAKERS

The following report was presented by Susan R. Bailey, MD, Speaker; and Bruce A. Scott, MD, Vice Speaker.

1. RECOMMENDATIONS FOR POLICY RECONCILIATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED
                                 RECOMMENDED ACTIONS ACCOMPLISHED

Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete."

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken in 2017. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to language will be made, additions are shown with underscore and deletions are shown with red strikethrough.

RECOMMENDED RECONCILIATIONS

Policy to be modified in light of later House of Delegates action

I.   G-600.027, "Designation of Specialty Societies for Representation in the House of Delegates"

This policy requires a minor change in the first paragraph given that the House amended the bylaws and adopted policy to implement the new procedure for apportioning delegates to national medical specialty societies. The change is a modest deletion from the policy and includes an appropriate capitalization in the first sentence. No other change to the policy is necessary.

   1. ~~The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and s~~ Specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request….

Policy to be modified for clarification and consistency with practice

II.   G-600.061, "Guidelines for Drafting a Resolution or Report"

The title of Policy G-600.061, "Guidelines for Drafting a Resolution or Report," suggests that it applies to both resolutions and reports, and in fact several parts of the policy refer specifically to both resolutions and reports. However, some subparagraphs of Paragraph 1 do not reference reports, despite the fact that practice has enforced the guidelines with respect to all reports submitted to the House, and the House of Delegates Reference Manual plainly states (page 30) that a fiscal note "indicating the financial implications of the report's recommendations" will be included. To ensure correspondence between the policy title and actual practice, the policy should explicitly address reports in Paragraphs 1, 1b, 1c and 1d.

   G-600.061, Guidelines for Drafting a Resolution or Report
   Resolutions or reports with recommendations to the AMA House of Delegates shall meet the following guidelines:

   1.   When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:

a. The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession;

b. The proposed policy should be clearly identified at the end of the resolution or report;

c. Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline;

d. A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution or report is estimated to have a resource implication of $50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.

2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.

3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.

4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.

5. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.

6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.

7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.

8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:
    a. New HOD Policy;
    b. Modify Current HOD Policy;
    c. Consolidate Existing HOD Policy;
    d. Modify Bylaws;
    e. Rescind HOD Policy;

    f.   Reaffirm HOD Policy; or
    g.   Directive to Take Action.

9. Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.

References to completed reports to be deleted from policies

The following policies will be modified by deleting references to requested reports that have been sent to and considered by the House of Delegates. Other, substantive portions of these directives are unchanged.

III. H-95.990, "Drug Abuse Related to Prescribing Practices"

The policy includes a request for a study that has been completed, so that section of the policy will be stricken. The remainder of the policy remains intact.

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
   A. institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
   B. placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:
   A. promotes physician training and competence on the proper use of controlled substances;
   B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
   C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
   D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. ~~The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.~~

~~4.~~ Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.

Council on Science and Public Health Report 2-I-13, "A Contemporary View of National Drug Control Policy," reviewed the material and addressed the elements of paragraph 3 within the Council's expertise. For that reason, paragraph 3 will be deleted.

IV. D-160.927, "Risk Adjustment Refinement in ACO Settings and Medicare Shared Savings Programs"

Our AMA will continue seeking the even application of risk-adjustment in ACO settings to allow Hierarchical Condition Category risk scores to increase year-over-year within an agreement period for the continuously assigned Medicare Shared Savings Program beneficiaries ~~and report progress back to this House at the 2017 Annual Meeting~~.

At the 2017 Annual Meeting, the Board of Trustees offered Report 21, "Risk Adjustment Refinement in Accountable Care Organization (ACO) Settings and Medicare Shared Savings Programs (MSSP)," which described efforts that had been undertaken to address the CMS policies and noted that our AMA would continue to urge CMS to improve risk adjustment methodology in ACOs.

V. D-165.935, "Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care"

~~1.~~ Our AMA will: (a) actively engage the new Administration and Congress in discussions about the future of health care reform, in collaboration with state and specialty medical societies, emphasizing our AMA's extensive body of policy on health system reform; and (b) craft a strong public statement for immediate and broad release, articulating the priorities and firm commitment to our current AMA policies and our dedication in the development of comprehensive health care reform that continues and improves access to care for all patients.

~~2. Our AMA Board of Trustees will report back to our AMA House of Delegates at the 2017 Annual Meeting.~~

BOT Report 24-A-17, "Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care," characterized the efforts that had been undertaken to that point, including engagement with the Federation, collaborations with various patient advocacy groups and letters to congressional leadership as well as the White House.

VI. D-478.970, Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging

Our AMA~~: (1) will study the medicolegal implications of text messaging and other non-HIPAA-compliant electronic messaging between physicians, patients, and members of the health care team, with report back at the 2017 Annual Meeting; and 2)~~ will develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients, and members of the health care team.

The report requested in part 1 of the policy was fulfilled by Board of Trustees Report 11-A-17, "Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging," which modified Policy H-478.997, "Guidelines for Patient-Physician Electronic Mail and Text Messaging," which remains current policy.

Policy with a title change

VII. D-478.964, "High Cost to Authors for Open Source Peer Reviewed Publications"

Following usual practice, Board of Trustees Report 10-I-17 took its title from the underlying referred resolution. While the body of the report correctly referred to open access journals, the title, taken directly from the resolution, employed the term "open source." As "open access" is the preferred terminology, the title of Policy D-478.964 will be changed to "High Cost to Authors for Open <u>Access</u> ~~Source~~ Peer Reviewed Publications."

Directives to be rescinded in full

The following directives will be rescinded in full, as the requested studies have been completed, with reports presented to the House of Delegates several years ago.

VIII.   D-160.930, "Studying Physician Access to ACO Participation"

Our AMA will study: (a) the criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. excluded from the ACO; (b) the criteria and processes by which physicians can be de-selected once they are members of an ACO; (c) the implications of such criteria and processes for patient access to care outside the ACO; and (d) the effect of evolving system alignments and integration on physician recruitment and retention. The results of this study will be reported back to the HOD and to our AMA membership at large by the 2015 Annual Meeting.

The directive was fulfilled by Council on Medical Service Report 7-A-15, "Physician Access to ACO Participation," which noted that efforts to identify and support current and emerging payment and care delivery models that work best for physicians across a variety of practice settings are ongoing.

IX.   D-165.940, "Monitoring the Affordable Care Act"

Our AMA will assess the progress of implementation of the Patient Protection and Affordable Care Act based on AMA policy, as well as the estimated budgetary, coverage and physician-practice impacts of the law, and report back to the House of Delegates at the 2013 Interim Meeting.

Council on Medical Service Report 5-I-13, "Monitoring the Affordable Care Act," was prepared in response to this directive.

The changes outlined above do not reset the sunset clock and will be implemented when this report is filed.