

REPORTS OF REFERENCE COMMITTEES OF THE AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES 2016 INTERIM MEETING

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

(1) BOARD OF TRUSTEES REPORT 5 – IOM “DYING IN AMERICA”
REPORT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 5 adopted.

Board of Trustees Report 5 reviews the Institute of Medicine’s “Dying in America” report, and examines the ways in which the report’s analysis and recommendations compare to the policies and programs of the AMA. Based on the findings of this examination, the report recommends that our AMA reaffirm existing AMA policies, which effectively promoted high-quality, patient-centered care for all patients at the end of life.

Testimony was overwhelmingly in favor of adoption of this report. Many believed it provided a thorough review of the IOM “Dying in America” report, and that it carefully compared and contrasted its recommendations with the existing policies of the AMA. Although some testimony spoke to amending the language of the report contained in the appendices, the reference committee noted that such changes were made in reference to material that was cited verbatim from the IOM report, and therefore, cannot be altered. Your Reference Committee recommends that Board of Trustees Report 5 be adopted.

(2) BOARD OF TRUSTEES REPORT 12 – SPECIALTY SOCIETY
REPRESENTATION IN THE HOD – FIVE-YEAR REVIEW

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 12 adopted.

Board of Trustees Report 12 reviewed specialty organizations seated in the House of Delegates that were scheduled to submit information and materials for the 2016 American Medical Association Interim Meeting in compliance with the five-year review process. The report recommends that the American Academy of Insurance Medicine, American Association of Clinical Endocrinologists, American Society for Gastrointestinal Endoscopy, American Society for Radiation Oncology, American Society for Surgery of the Hand, American Urological Association, AMSUS-The Society of Federal Health Professionals, North American Spine Society, Society for Vascular Surgery, and Society of American Gastrointestinal and Endoscopic Surgeons retain representation in the American Medical Association House of Delegates. The report also recommends that, having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.50, the American Academy of Sleep Medicine, American Society of Cytopathology, and American Society of Plastic Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.

The Board of Trustees introduced this report and there was no further testimony. Your Reference Committee recommends that Board of Trustees Report 12 be adopted.

(3) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 –
MEMBERSHIP AND REPRESENTATION IN THE ORGANIZED MEDICAL
STAFF SECTION – UPDATED BYLAWS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws Report 1 adopted.

Council on Constitution and Bylaws Report 1 addresses updated bylaws for the membership and representation in the Organized Medical Staff Section (OMSS). The report recommends that the amendments to the AMA Bylaws on OMSS be adopted with regard to changes to Membership, Representatives to the Business Meeting, Cessation of Eligibility, and Member Rights and Privileges, and that Policy G-615.101 be rescinded.

The Council on Constitution and Bylaws introduced this report and there was no further testimony. Your Reference Committee recommends that Council on Constitution and Bylaws Report 1 be adopted.

(4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 –
COMPETENCE, SELF-ASSESSMENT AND SELF AWARENESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 2 referred.

Council on Ethical and Judicial Affairs Report 2 deals with the topic of physician competence, self-assessment, and self-awareness. Central to medicine is the expectation that a physician will provide competent care, and this report looks at the benefits and limits of self-assessment, what it means to maintain expertise in one's specialty and general medical knowledge, and the implicit and explicit influences that can shape a physician's competence and self-awareness. The report offers ethical guidance on how individual physicians (at all career stages) can engage in greater self-reflection, and how the medical profession itself can refine the mechanisms it uses to meaningfully assess physician competence.

This report received an equal amount of support for adoption and referral. Testimony against the report pointed to concerns around the aging physician, cognitive decline, and other chronic and short-term conditions that may be stigmatized by the report and its guidance. Some noted that there are often times in a physician's life when they are not in peak condition, yet that does not mean they are unable to provide quality care to patients. Other testimony highlighted concerns about who will ultimately make the determination of what competence in practice means. Testimony from the senior physicians was particularly supportive. Based on the testimony heard, the reference committee felt the report offered appropriate and useful guidance for physicians to assist them in assessing their competence to practice medicine and provide quality patient care. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be adopted.

(5) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2 – BYLAW AMENDMENTS PERTAINING TO LATE RESOLUTIONS AND EMERGENCY BUSINESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Constitution and Bylaws Report 2 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Constitution and Bylaws Report 2 be referred.

HOD ACTION: Council on Constitution and Bylaws Report 2 adopted as amended.

Council on Constitution and Bylaws Report 2 addresses changes to the definitions of late and emergency resolutions, outlines the handling of this resolutions from delegates, and considers whether some elements currently in the bylaws related to the handling of late and emergency business would be more appropriately defined in policy. The report asks that our AMA adopt the amended language regarding late and emergency resolutions in order to add greater clarity and efficiency when handling these items of business.

Testimony regarding the first recommendation of this report was limited. The Council on Constitution and Bylaws spoke briefly about this recommendation noting the current need for implementing the bylaws changes regarding handling late and emergency resolutions in the House. As there was no objection to the content of this recommendation, your Reference Committee recommends that Recommendation 1 of Council on Constitution and Bylaws Report 2 be adopted.

Testimony for this recommendation was met with considerable confusion, with most favoring referral. House leadership stated that the Board of Trustees wants to be transparent in its processes, but it was clear from testimony that as worded, rules regarding voting parameters for consideration and/or adoption does not accomplish this goal. Similar concerns were raised regarding other processes outlined by the recommendation due to ambiguous language. Current and past members of the Council on Constitution and Bylaws offered recommended that in order to appropriately remedy these problems, the recommendation should be referred back to the Council for further consideration. Therefore, your Reference Committee recommends that Recommendation 2 of Council on Constitution and Bylaws Report 2 be referred.

(6) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 – COLLABORATIVE CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted as amended by CEJA on page 7, line 23 to read as follows:

(a) Model ~~ethical~~ leadership by:

and the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 1 adopted.

Council on Ethical and Judicial Affairs Report 1 examines the ethical issues inherent in the provision of physician-lead collaborative care. Within collaborative care teams, physicians and other health care professional must work in concert to provide high quality patient-centered care, establish mutual respect and trust throughout the team,

maintain avenues of communication, and uphold accountability for all team members. The report outlines the types of leadership physicians should consider in leading such teams, the variety of challenges collaborative care teams frequently encounter, and offers ethical guidance on how physician leaders can promote and encourage the many qualities that constitute an effective collaborative care team.

Testimony for this report was mixed. While the report received praise for addressing this timely issue, conflicting concerns were heard about the ethical guidance contained therein. Some felt that the report lacked clarity in determining who should serve in a leadership role on a collaborative care team, yet others desired more openness in the report in order to allow a greater variety of team members to assume this role. Concerns were also expressed about the possibility of the report's language being misused by insurance companies or hospitals to punish physicians. Of particular concern was the use of the word "ethical" in recommendation (a) of the guidance, indicating a high bar of conduct physicians might not be unable to attain in their practice. During its deliberations, your Reference Committee felt that content and analyses of the report were well considered and appropriate, but that the report could be improved by the deletion of the word "ethical" in recommendation (a). The Council on Ethical and Judicial Affairs was open to this suggestion and agreed to the editorial change. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted.

(7) RESOLUTION 3 – STUDY OF THE CURRENT USES AND ETHICAL IMPLICATIONS OF EXPANDED ACCESS PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 3 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the implementation of expanded access programs, accelerated approval mechanism, and payment reform models meant to increase access of ~~experimental~~ to investigational therapies, including programs for infants and children (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 3 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA study the ethics of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of ~~experimental~~ to investigational therapies, including access for infants and children. (Directive to Take Action).

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 3 be adopted as amended.

HOD ACTION: Resolution 3 adopted as amended.

Resolution 3 addresses recent actions at the federal and state level regarding expanded access (i.e., "right to try") programs that allow terminally ill patients greater accessibility to investigational drug treatments. The resolution asks that our AMA study the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies. Furthermore, the resolution asks that our AMA study the ethics of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies.

Testimony for this resolution was limited. Those offering testimony agreed that additional research is needed to inform future policy and laws, but that pediatric populations need to be included in this research agenda. Therefore, your Reference Committee recommends that Resolution 3 be adopted as amended.

(8) RESOLUTION 4 – ADDRESSING PATIENT SPIRITUALITY IN MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 4 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association recognize ~~support inquiry into, as well as discussion and consideration of,~~ the importance of individual patient spirituality ~~as an important component of health~~ and its impact on health (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 4 be amended by deletion to read as follows:

RESOLVED, That our AMA encourage ~~expanded patient access to spiritual care services, and resources beyond trained healthcare professionals.~~ (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 4 be adopted as amended.

HOD ACTION: Resolution 4 adopted as amended.

Resolution 4 addresses the inclusion of religious and spiritual needs of patients in their medical care. The resolution asks that our AMA support inquiry into, as well as discussion and consideration of, individual patient spirituality as an important component of health, and that our AMA encourage expanded patient access to spiritual care services and resources beyond those provided by trained health care professionals.

Testimony largely supported this resolution. Those in favor of adoption discussed the importance spirituality plays in a patient's care, with research showing that patients who have their spiritual needs met during the course of their medical care demonstrate improved health outcomes. Reservations were expressed about the wording of the resolutions, however, particularly for the second resolve which led some to believe that it promoted an unfunded mandate. Based on the testimony heard, your Reference Committee recommends that Resolution 4 be adopted as amended.

(9) RESOLUTION 5 – NO COMPROMISE ON ANTI-FEMALE GENITAL MUTILATION POLICY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 5 be amended by deletion to read as follows:

RESOLVED, That, ~~due to the public debate in 2016 over whether the medical community sanctions a proposed ‘nicking procedure,’~~ our AMA condemns any and all forms of female genital mutilation ~~ritual procedures including, but not~~

~~limited to, ‘nicking’ or ‘genital alteration’ procedures done to the genitals of women and girls (New HOD Policy); and be it further~~
RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 5 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA, on behalf of the medical community, actively advocate against the practice of female genital mutilation FGM in all its forms. (including the recently proposed ‘nicking’ and ‘alteration’ procedures) and effectively add the voice of America’s physicians to the voices of many anti-FGM activists and their organizations which advocate for the survivors and victims of FGM (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends amendment by deletion of the fourth Resolve of Resolution 5:

~~RESOLVED, That our AMA partner in this public advocacy with reputable anti-FGM activists and survivors including, but not limited to, Jaha Dukureh of the Tahirih Justice Center, Waris Dirie of Desert Flower Foundation, Layla Hussein of the Maya Center and the Dahlia Project, and Nimco Ali of the Daughters of Eve or Safe Hands for Girls to name a few (Directive to Take Action); and be it further~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 5 be amended by addition of a new fifth Resolve to read as follows:

RESOLVED. That it is unethical for physicians to engage in the practice of female genital mutilation in all its forms. (New HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 5 be amended by addition of a new sixth Resolve to read as follows:

RESOLVED, That our AMA considers that the practice of female genital mutilation on minors is child abuse. (New HOD Policy)

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Resolution 5 be adopted as amended.

HOD ACTION: Resolution 5 referred.

Resolution 5 addresses the issue of female genital mutilation (FGM) and recent attempts by some academics and physicians to redefine FGM and take a compromised position on its practice. The resolution asks that our AMA do the following: 1) reaffirm its policy against FGM, 2) further clarify its current position on FGM to explicitly state that our AMA condemns any and all ritual procedures including, but not limited to, ‘nicking’ or ‘genital alteration’ procedures done to the genitals of women and girls, 3) actively advocate against the practice of FGM in all its forms and effectively add the voice of America’s physicians to the voices of many anti-FGM human rights activists and their organizations which advocate for the survivors and victims, 4) partner in the public advocacy with reputable

anti-FGM activists and survivors, and 5) educate its membership and the American public about the harm of FGM prominently through its website and provide resources about the ethics and medical harm of any and all forms of FGM.

Testimony strongly favored the spirit of this resolution, with disagreement focusing largely over the language of the resolve clauses. Many supported the first resolve, but found resolves two through five to be unnecessarily inflammatory. Others noted that despite the importance of the issue of female genital mutilation, cultural traditions around its practice are not necessarily black and white, and that the language of AMA policy should recognize this ambiguity. However, the reference committee, based on some testimony but also their knowledge of the great psychological and physical harms of this practice, as well as the rationale driving this practice, believes that female genital mutilation in any form is an extreme violation of one's body, autonomy, and psyche. When this practice is done in any form upon a minor, it is nothing less than child abuse. Given the testimony heard and the deliberations of the reference committee, the reference committee feels that amended language to the resolution best addresses the aims of the resolution in a compromised fashion. Your Reference Committee recommends that Resolution 5 be adopted as amended.

(10) RESOLUTION 6 – EFFECTIVE PEER REVIEW

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 6 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the current environment for effective peer review, on both a federal and state basis, in order to update its current policy to include strategies for promoting effective peer review by ~~employed~~ physicians and to as well consider a national strategy for protecting all physicians from retaliation as a result from participating in effective peer review. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 6 be adopted as amended.

HOD ACTION: Resolution 6 adopted as amended.

Resolution 6 addresses the peer review system for removing incompetent physicians from practice, but notes that current AMA policy does not appear to reflect the dramatic recent change in workplace arrangements nor protect employed physicians from retaliation as a result of participation in effective peer review. The resolution asks that our AMA study the current environment for effective peer review, on both a federal and state basis, in order to update its current policy to include strategies for promoting effective peer review by employed physicians as well as consider a national strategy for protecting all physicians from retaliation as a result from participating in effective peer review.

Testimony for this resolution was overwhelmingly in support of adoption, with some amendments offered to clarify language. Testimony spoke to the increasing number of physicians who are employed in large hospital systems or health care organizations where they exert less and less control over their employment situations and patient care. As a result, having effective, legitimate peer review processes in place can offer greater protections. Given the importance of having quality peer review systems in place that can prevent retaliatory actions by employers, those offering testimony lauded the need for further study by the AMA on this topic. To a lesser extent, some questions were raised about the language of the resolve clauses and whether the resolution as currently worded could have unintended consequences for pursuing this study. Your Reference Committee recommends that Resolution 6 be adopted as amended.

(11) RESOLUTION 7 – FAIR PROCESS FOR EMPLOYED PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 7 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support whistleblower protections for health care ~~providers~~ professionals and parties who raise questions ~~of that include, but are not limited to, issues of~~ quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 7 be adopted as amended.

HOD ACTION: Resolution 7 adopted as amended.

Resolution 7 addresses fair processes for employed physicians given that employed physicians face unique challenges that may contribute to physician burnout, including fears of retaliation. Resolution 7 asks that our AMA support whistleblower protections for health care providers and parties who raise questions of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity. Furthermore, the resolution asks that our AMA advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace.

Testimony was unanimously in support of this resolution. All testimony spoke to the need for greater protections for physicians who raise questions of quality, safety and efficacy within their health care organization, and that the AMA should support these physicians in their efforts. Some minor amendments were offered to clarify the goals of the resolve clauses. Your Reference Committee recommends that Resolution 7 be adopted as amended.

(12) RESOLUTION 8 – BLOOD DONOR DEFERRAL CRITERIA REVISIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 8 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-50.973 by addition and deletion to read as follows:

Blood Donor Deferral Criterial H-50.973

Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of individual risk; and (2) opposes all policies the current lifetime a on deferral on of blood and tissue donations from men who have sex with men that are not based on the in science-scientific literature; and (3) supports research into Individual Risk Assessment criteria for blood donation. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 8 be adopted as amended.

HOD ACTION: Resolution 8 adopted as amended.

Resolution 8 asks that the AMA amend Policy H-50.973 Blood Donor Deferral Criteria to support research into Individual Risk Assessment criteria for blood donation and to oppose deferral of blood and tissue donations from men who have sex with men which are not based in science.

Testimony was largely in favor of adopting this resolution. All those offering testimony briefly spoke of the discriminatory nature of the blood donation deferral policy, and supported amending the AMA's existing policy on this topic. Your Reference Committee recommends that Resolution 8 be adopted as amended.

(13) BOARD OF TRUSTEES REPORT 6 – DESIGNATION OF SPECIALTY SOCIETIES FOR REPRESENTATION IN THE HOUSE OF DELEGATES**RECOMMENDATION:**

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 6 be referred.

HOD ACTION: Board of Trustees Report 6 adopted as amended.

1. That the current specialty society delegation allocation system (using a formula that incorporates the ballot) be discontinued; and that specialty society delegate allocation in the House of Delegates 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. (Directive to Take Action)

2. b) iii) In the case of a tie, the previous year's data will be used as a tie breaker. In the case of an additional delegate being necessary, the society that was closest to gaining a delegate in the previous year will be awarded the delegate. In the case of a delegate reduction being necessary, the society that was next closest to losing a delegate in the previous year will lose a delegate. (Directive to Take Action)

Board of Trustees Report 6 addresses the issue of the representation of specialty societies in the House of Delegates. This report recommends that the current specialty society delegate allocation system be discontinued, and that specialty society delegate allocation be determined in a manner 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 of AMA bylaws, and that this distribution is based on the latest available membership data for each society.

Testimony for this report was strongly in favor of adoption. Following several attempts to address specialty society representation, the report was commended as being the best solution to date for addressing this complicated formula. Representatives from specialty societies that are directly affected by the recommendations of this report were particularly in support of adoption. Confusion around the practical operation of the report's recommendations started to arise, however, based on questions presented during the hearing and executive session. The Reference Committee feels that these questions need to be addressed before the report can be adopted. Your Reference Committee suggests that the following ambiguities should be addressed: how does inclusion of new specialty societies (especially halfway through the year) impact parity with state numbers; what happens when two specialty societies are equally qualified to lose or gain a delegate but there is only one delegate to be lost or gained; how is parity achieved when states are evaluated yearly but specialty societies are not; and how often (during the five year review or at mandatory or optional other intervals?) is specialty society membership calculated. Your Reference Committee therefore recommends that Board of Trustees Report 6 be referred.

(14) BOARD OF TRUSTEES REPORT 7 – SUPPORTING AUTONOMY FOR PATIENTS WITH DIFFERENCES OF SEX DEVELOPMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 7 be referred.

HOD ACTION: Board of Trustees Report 7 referred.

Board of Trustees Report 7 focuses on the autonomous decision making of pediatric patients born with differences of sex development (DSD), specifically the issue of medically necessary versus medically unnecessary procedures for those with DSD. The report recommends that our AMA support optimal management of DSD through individualized, multidisciplinary care that: (1) seeks to foster the well-being of the child and the adult he or she will become; (2) respects the rights of the patient to participate in decisions and, except when life-threatening circumstances require emergency intervention, defers medical or surgical intervention until the child is able to participate in decision making; and (3) provides psychosocial support to promote patient and family well-being.

The testimony for this report was largely in favor of referral, although there were some who spoke in favor of adoption. Those supporting the report and its recommendation noted that its content was thoughtful and matched the policies of other organizations working on difference in sex development issues. Despite this support, many concerns were heard regarding the unintended consequences of the report recommendation (particularly around interventions that may be clinically necessary but not life-threatening or emergent) and the lack of expert insight on the medical complexities inherent in addressing difference of sex development in pediatric patients. Testimony noted that when this report is reconsidered, the recommendations should be developed in collaboration with experts in pediatric endocrinology, urology, psychiatry and law. Therefore, your Reference Committee recommends that Board of Trustees Report 7 be referred.

(15) BOARD OF TRUSTEES REPORT 8 – MEDICAL REPORTING FOR SAFETY SENSITIVE POSITIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 8 be referred.

HOD ACTION: Board of Trustees Report 8 referred.

Board of Trustees Report 8 examines the topic of mandatory reporting of significant medical conditions for employees in safety sensitive positions in order to better protect the public. The report finds that national standards already exist for employees in safety-sensitive positions for their physical and mental health, which require employees to be cleared for work by DOT-certified physicians, and that the likely gain in public safety that would be achieved by mandatory reporting is at present undemonstrated. The report, therefore, recommends that our AMA not adopt resolution 14-A-16, “Medical Reporting for Safety-Sensitive Positions.”

The testimony for this report was limited. The authors of the resolution calling for the creation of this report felt strongly that the report content missed the resolution’s original intent. Although there are systems in place to screen pilots and others in safety sensitive positions for serious medical conditions, it was stated that these patients often look for medical care outside of these systems, and subsequently fail to be reported. In light of the report’s deficiencies, it was suggested in the testimony that the Council on Ethical and Judicial Affairs update its existing opinion 8.2 (Impaired Drivers and Their Physicians) and opinion 9.3.2 (Physician Responsibilities to Impaired Colleagues) in consideration of the content of the Pilot Bill of Rights. The reference committee suggests a different approach. Because of the failure of the report to accurately address the ethical and public health dimensions of this subject, your Reference Committee felt that the issues of safety sensitive positions should be examined through a joint report of the Council on Ethical and Judicial Affairs and the Council on Science and Public Health. Your Reference Committee recommends that Board of Trustee Report 8 be referred.

(16) RESOLUTION 1 – SUPPORT FOR THE DECRIMINALIZATION AND TREATMENT OF SUICIDE ATTEMPTS AMONGST MILITARY PERSONNEL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-345.994, Policy H-60.937, Policy D-510.996, Policy H-65.965, and Policy H-510.988 be reaffirmed in lieu of Resolution 1.

HOD ACTION: Policy D-345.994, Policy H-60.937, Policy D-510.996, Policy H-65.965, and Policy H-510.988 reaffirmed in lieu of Resolution 1.

Resolution 1 addresses the issue of suicide attempts in the military, which, since 1949, have been treated by the Department of Defense with criminal charges regardless of the intent of the service member. The resolution asks that our AMA support efforts to decriminalize suicide attempts in the military, and that our AMA support efforts to provide treatment for attempted suicide survivors in lieu of punishment by the military.

Testimony for this resolution was largely in favor of spirit of the resolution, though there was debate as to whether to adopt the resolution or support reaffirmation of existing AMA policy. All agreed that it is wrong for the military to criminally punish its members who have attempted suicide. Testimony revealed that the practice of doing so is outdated. Those serving in the military and those who treat members of the military stated that they have never witnessed this practice, and that military personnel who have attempted suicide have received appropriate medical treatment for their conditions, not criminal sanctions. Attention was also drawn to changes in federal military policy that are in the process of addressing this controversial issue. The Reference Committee strongly condemns the criminal punishment of attempted suicide by members of the military; however, in light of the evidence presented during the hearing, supports the reaffirmation of current AMA policy. Therefore, your Reference Committee recommends that Policy D-345.994, Policy H-60.937, Policy D-510.996, Policy H-65.965, and Policy H-510.988 be reaffirmed in lieu of Resolution 1.

D-345.994 Increasing Detection of Mental Illness and Encouraging Education

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment. Res. 412, A-06 Appended: Res. 907, I-12

H-60.937 Teen and Young Adult Suicide in the United States

Our AMA recognizes teen and young-adult suicide as a serious health concern in the US. Res. 424, A-05 Reaffirmed: CSAPH Rep. 1, A-15

D-510.996 Military Care in the Public and Private Sector

Our AMA will use its influence to expedite quality medical care, including mental health care, for all military personnel and their families by developing a national initiative and strategies to utilize civilian health care resources to complement the federal health care systems. Res. 444, A-07

H-65.965 Support of Human Rights and Freedom

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex,

sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. CCB/CLRPD Rep. 3, A-14

H-510.988 Supporting Awareness of Stress Disorders in Military Members and Their Families

Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of Defense and the Department of Veterans Affairs. Sub. Res. 401, A-10

(17) RESOLUTION 2 – LIVING ORGAN DONATION AT THE TIME OF IMMINENT DEATH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-370.959, Policy D-370.985, Policy H-370.964, and Policy H-370.961 be reaffirmed in lieu of Resolution 2.

HOD ACTION: Policy H-370.959, Policy D-370.985, Policy H-370.964, and Policy H-370.961 reaffirmed in lieu of Resolution 2.

Resolution 2 addresses the issue of living organ donation at the time of imminent death for the donor. The resolution asks our AMA to study the implications of the removal of barriers to living organ donation at the time of imminent death.

Testimony for this resolution was mixed. Those in support of the resolution focused on the resolution's call to study living organ donation at the time of imminent death, particularly given the dire needs of organ recipients in the United States. Additional support for the resolution recommended a multidisciplinary approach to studying this topic, including incorporating the insight of outside experts in the field of transplantation. Others stood against this resolution, pointing out that the United Network for Organ Sharing ethics committee recently conducted a study of this topic, and concluded that it was too contentious and not feasible. While several amendments were offered to help focus the goals of this resolution, your Reference Committee determined that existing AMA policy properly addresses the request of the resolution to study methods of increasing organ donation. Your Reference Committee recommends that Policy H-370.959, Policy D-370.985, Policy H-370.964, and Policy H-370.961 be reaffirmed in lieu of Resolution 2.

H-370.959 Methods to Increase the US Organ Donor Pool

In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues. BOT Rep. 13, A-15

D-370.985 Organ Donation

Our AMA will study potential models for increasing the United States organ donor pool. Res. 1, A-14
Reaffirmed in lieu of Res. 5, I-14

H-370.964 Surrogate Consent for Living Organ Donation

Our AMA opposes the practice of surrogate consent for living organ donation from patients in a persistent vegetative state. Res. 7, A-12

H-370.961 Ethical Procurement of Organs for Transplantation

Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary. BOT Rep. 13, A-08

- (18) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OPINION 1 –
MODERNIZED CODE OF MEDICAL ETHICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Opinion 1 be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Opinion 1 filed.

Council on Ethical and Judicial Affairs Opinion 1 files the modernized Code of Medical Ethics, which was adopted in whole at the 2016 Annual Meeting of the House of Delegates.

Testimony on this opinion was limited, and focused on developing a better understanding of the processes by which Council on Ethical and Judicial Affairs reports are adopted by the House and then developed as opinions. Although some small changes were made to the language of CEJA Report 1 following the adoption of the modernized Code of Medical Ethics at A-16, the changes reflected testimony heard at that meeting and no concern was raised about this new language. Members from CEJA addressed questions posed during testimony, offering greater insight to finalization of the opinion. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Opinion 1 be filed.

- (19) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OPINION 2 –
ETHICAL PRACTICE IN TELEMEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Opinion 2 be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Opinion 2 filed.

Council on Ethical and Judicial Affairs Opinion 1 files the opinion on Ethical Practice in Telemedicine, which was adopted at the 2016 Annual Meeting of the House of Delegates.

Council on Ethical and Judicial Affairs was unintentionally extracted and there were no concerns with the opinion. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Opinion 2 be filed.

- (20) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 – CEJA
AND HOUSE OF DELEGATES COLLABORATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 3 be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 3 referred.

Policy D-600.957, adopted at A-16, asked the AMA to evaluate (1) how the collaborative process between the House of Delegates and the Council on Ethical and Judicial Affairs can best be improved to allow HOD input to CEJA deliberation while still preserving CEJA autonomy; and (2) how a periodic review of *Code of Medical Ethics* guidelines and reports can best be implemented. This report proposes several ways in which these can be accomplished.

Testimony for this report highlighted concerns as to whether report accurately addressed the resolution that prompted its creation. The authors of the resolution stated that the original resolves of the resolution identified six points that were to be addressed by the Council on Ethical and Judicial Affairs, and more broadly, the HOD. However, those providing testimony felt that none of those points had been addressed regarding CEJA's collaborative process, and that the report itself was the opposite of the process they had hoped to engage in. Therefore, your Reference Committee recommends that CEJA Report 3 be filed.

(21) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 4 – ETHICAL PHYSICIAN CONDUCT IN THE MEDIA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 4 be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 4 filed.

Council on Ethical and Judicial Affairs Report 4 is an informational report with a status update on the response to Policy D-140.957 which seeks to address concerns about the conduct of physicians who make medical information available to the public through various media outlets.

This informational report was extracted from the consent calendar and heard in reference committee. The concern and reason for extraction was that it errantly states that the final report will not explicitly acknowledge conflicts of interest, which was a particular concern in the original resolution. However, the final report will in fact address conflicts of interest. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 4 be filed.

REPORT OF REFERENCE COMMITTEE B

(1) RESOLUTION 201 - REMOVING RESTRICTIONS ON FEDERAL FUNDING FOR FIREARM VIOLENCE RESEARCH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 201 be adopted.

HOD ACTION: Resolution 201 adopted.

Resolution 201 asks that our American Medical Association provide an informational report on recent and current organizational actions taken on our existing AMA policies regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Your Reference Committee heard minimal but supportive testimony in favor of this resolution. Testimony supported studies of our AMA's advocacy in this area and noted that this is important work that should be carried through to the new Administration. Other testimony in support of this resolution stated that our AMA should expand advocacy in this area generally. Therefore, our Reference Committee recommends that Resolution 201 be adopted.

(2) RESOLUTION 203 - UNIVERSAL PRESCRIBER ACCESS TO PRESCRIPTION DRUG MONITORING PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 203 be adopted.

HOD ACTION: Resolution 203 adopted.

Resolution 203 asks that our American Medical Association support legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.

Your Reference Committee heard unanimous support for Resolution 203. Your Reference Committee agrees that it is critical for resident physicians, who routinely prescribe controlled substances for their patients including opioid pain medications, to have access to their state's prescription drug monitoring program (PDMP). Since most state laws do not explicitly grant resident physicians access to PDMPs, your Reference Committee agrees that it is appropriate for our AMA to support legislation and regulatory action that would allow residents such access. Your Reference Committee recognizes testimony related to the need to include "designated licensed office and/or hospital personnel." Not only does your Reference Committee believe that this resolution's focus should remain on residents, but we also want to point out that existing AMA policy covers the concerns raised related to "other designated licensed office and/or hospital personnel." Specifically, H-95.939, entitled "Development and Promotion of Single National Prescription Drug Monitoring Program," states, "Our American Medical Association . . . 3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law." As a result, your Reference Committee recommends that Resolution 203 be adopted.

- (3) RESOLUTION 204 - SEAMLESS CONVERSION OF MEDICARE ADVANTAGE PROGRAMS
 RESOLUTION 210 - AUTOMATIC ENROLLMENT INTO MEDICARE ADVANTAGE
 RESOLUTION 216 - ENDING MEDICARE ADVANTAGE "AUTO-ENROLLMENT"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 216 be adopted in lieu of Resolution 204 and Resolution 210.

HOD ACTION: Resolution 216 adopted in lieu of Resolution 204 and Resolution 210.

Resolution 204 asks that our American Medical Association collaborate with senior groups, including AARP, to raise awareness among physicians and seniors regarding the implications of the practice of “seamless conversion”; and be it further, that our AMA immediately begin to advocate with Congress and the Centers for Medicare and Medicaid Services to implement an immediate moratorium on the practice of seamless conversion.

Resolution 210 asks that our American Medical Association work to make seamless conversion enrollment into a Medicare Advantage Plan an opt-in rather than an opt-out process.

Resolution 216 asks that our American Medical Association work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of “auto-enrollment” of individuals into Medicare Advantage Plans.

Your Reference Committee heard strong testimony in support of Resolution 216, which your Reference Committee believes is broad and strong enough to accomplish the goals of Resolutions 204 and 210. Your Reference Committee also heard that, due to AMA advocacy efforts, on October 24, 2016, CMS announced that it has temporarily stopped accepting new proposals from health insurance companies seeking to automatically enroll their commercial beneficiaries into their Medicare Advantage plans. Adoption of Resolution 216 is thus consistent with AMA past, current, and future advocacy on Medicare Advantage plans. For these reasons, your Reference Committee recommends adoption of Resolution 216 in lieu of Resolutions 204 and 210.

- (4) RESOLUTION 214 - FIREARM-RELATED INJURY AND DEATH: ADOPT A CALL TO ACTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 214 be adopted.

HOD ACTION: Resolution 214 adopted.

Resolution 214 asks that our American Medical Association endorse the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American Congress of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication “Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association,” which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Your Reference Committee heard extensive, passionate, and supportive testimony related to Resolution 214. Like those testifying, your Reference Committee commends the eight national health professional organizations, including the American Academy of Family Physicians, American Academy of Pediatrics, American College of

Emergency Physicians, American Congress of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, and American Public Health Association, as well as the American Bar Association, for articulating and advocating a series of measures aimed at reducing the health and public health consequences of firearms. AMA policy is wholly consistent with the recommendations contained within the publication articulating these measures, titled "[Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association](#)," published within the April 7, 2015 edition of the *Annals of Internal Medicine*. Your Reference Committee recognizes the concern raised by several individuals related to referencing specific articles, documents, etc., in AMA policy. However, your Reference Committee believes that in this instance it is appropriate and without risk. Our AMA already has policy that supports every tenant in the document at issue. Moreover, AMA staff, as well as the AMA Council on Legislation, have thoroughly reviewed this publication and are comfortable with our AMA endorsing it in its entirety. At this time, we do not believe it is necessary to summarize the specific recommendations made in this document and as a result of doing so, creating new (essentially redundant) policy. Therefore, your Reference Committee recommends that Resolution 214 be adopted.

(5) RESOLUTION 218 - SUPPORT FOR PRESCRIPTION DRUG MONITORING PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 218 be adopted.

HOD ACTION: Resolution 218 adopted.

Resolution 218 asks that our American Medical Association continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and be it further, that our AMA work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.

Your Reference Committee heard limited but unanimously supportive testimony for Resolution 218. Your Reference Committee agrees that funding of state prescription drug monitoring programs (PDMPs) is critical and, therefore, recommends that Resolution 218 be adopted.

(6) RESOLUTION 220 - DISTRACTED DRIVER REDUCTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 220 be adopted.

HOD ACTION: Resolution 220 adopted.

Resolution 220 asks that our American Medical Association develop model state legislation to limit cell phone use to hands-free use only while driving.

Your Reference Committee heard strong support for Resolution 220. AMA policy, H-15.952, entitled "The Dangers of Distraction While Operating Hand-Held Devices," already provides "2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving." Your Reference Committee received a report indicating that 46 states and the District of Columbia (DC) prohibit texting while driving and 14 states and the DC prohibit all drivers from using hand-held cell phones while driving, thereby providing a strong basis of sample legislative best practices from which to draw. Your Reference Committee also received information that our AMA state Advocacy Resource Center is already working with interested state medical associations and national medical specialty societies across the country in implementing our existing policy. Given the passionate support for Resolution 220, and specifically, the interest in model state legislation, your Reference Committee recommends adoption.

(7) BOARD OF TRUSTEES REPORT 2 - AMA SUPPORT FOR STATE MEDICAL SOCIETIES' EFFORTS TO IMPLEMENT MICRA-TYPE LEGISLATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second recommendation of Board of Trustees Report 2 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ~~the efforts of interested~~ state medical associations in their opposition to defeat efforts to replace proposals to replace a state medical liability system with a no-fault liability or Patient Compensation System, unless those proposals are consistent with AMA policy. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 2 adopted as amended.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 214-I-15 and that the remainder of the report be filed: that our American Medical Association (AMA) reaffirm Policy H-435.967, "Report of the Special Task Force and the Advisory Panel on Professional Liability" and that our AMA support the efforts of interested state medical associations to defeat efforts to replace a state medical liability system with a no-fault liability or Patient Compensation System.

Your Reference Committee heard generally supportive testimony on Board of Trustees Report 2. Your Reference Committee heard testimony from several states that have considered, or are expecting to consider, legislation proposing no-fault liability systems. For many of the reasons outlined in this Board Report, all such states have opposed such proposals. This testimony suggested that the support of our AMA in these state legislative efforts would be welcome. At the same time, your Reference Committee offers an amendment to respond to testimony intended to ensure that our AMA maintains the flexibility to support innovative medical liability reforms that are consistent with AMA policy, such as the National Vaccine Injury Compensation program and birth related neurological injury compensation funds. For these reasons, as well as the reasons stated in the Board's excellent and thorough report, your Reference Committee recommends that the recommendations of Board of Trustees Report 2 be adopted as amended and the remainder of the report be filed.

(8) BOARD OF TRUSTEES REPORT 3 - MODEL STATE LEGISLATION PROMOTING THE USE OF ELECTRONIC TOOLS TO MITIGATE RISK WITH PRESCRIPTION OPIOID PRESCRIBING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 of Board of Trustees Report 3 be amended by addition and deletion to read as follows:

4. That our AMA ~~support~~ advocate for the interoperability of state PDMPs with electronic health records (EHRs) ~~(New HOD Policy)~~ (Directive to Take Action);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 3 adopted as amended.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 222-I-15, and that the remainder of the report be filed; and that our American Medical Association (AMA) support the ability of prescription drug monitoring programs (PDMPs) to have the capability for physicians to know when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame; and that our AMA advocate to key stakeholders, including the National Association of State Controlled Substances Authorities, the National Association of Boards of Pharmacy, and the National Governors Association, to ensure that efforts to reduce Multiple Provider Events (MPEs) are done in a manner that supports continuity of care; and that our AMA work with the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA) and other relevant federal agencies, to better understand the factors that lead to MPEs and develop medically and ethically appropriate strategies for reducing them; and that our AMA support the interoperability of state PDMPs with electronic health records (EHRs); and that Policies D-478.972, "EHR Interoperability," D-478.994, "Health Information Technology," and D-478.996, "Information Technology Standards and Costs," be reaffirmed; and that our AMA advocate for the Centers for Medicaid and Medicare Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) to better incorporate feedback from physicians to focus on outcomes and focusing ONC certification on testing for product safety, security, usability, and interoperability.

Your Reference Committee commends the Board of Trustees for an extensive, thorough, and well written report and we laud our AMA's leadership in forming our AMA's Task Force to Reduce Opioid Abuse. Your Reference Committee recognizes that one of the Task Force's areas of focus includes the support of physicians registering for and using prescription drug monitoring programs (PDMPs). PDMP use is essential, as is PDMP integration with electronic health records (EHRs). Your Reference Committee agrees with the widespread support heard for Board of Trustees Report 3. Therefore, your Reference Committee recommends that the report be adopted as amended and the remainder of the report be filed.

- (9) RESOLUTION 202 - INCLUSION OF SEXUAL ORIENTATION AND GENDER IDENTITY INFORMATION IN ELECTRONIC HEALTH RECORDS
RESOLUTION 212 - PROMOTING INCLUSIVE GENDER, SEX, AND SEXUAL ORIENTATION OPTIONS ON MEDICAL DOCUMENTATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the First Resolve of Resolution 212 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s), ~~and (if applicable) surrogate identifications~~ in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 212 be adopted as amended in lieu of Resolution 202.

HOD ACTION: Resolution 212 adopted as amended.

Resolution 202 asks that our American Medical Association advocate for inclusion of sexual orientation and gender in electronic health records (EHRs).

Resolution 212 asks that our American Medical Association support the inclusion of a patient's biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and (if applicable) surrogate identifications in medical documentation and related forms in a culturally-sensitive and voluntary manner; and be it further that our AMA advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 202, noting that the inclusion of this patient data in medical documentation is paramount to providing quality care to the LGBT community. Your Reference Committee agrees with testimony that information about a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) should be collected and included in medical documentation and related forms, in a culturally-sensitive and voluntary manner. Your Reference Committee also agrees such information should be included in electronic health records (EHRs), if utilized. However, your Reference Committee believes that the scope and definition of "surrogate identification" is unclear, and encourages the sponsor of Resolution 212 to clarify and educate our House of Delegates about this term and its relation to medical documentation. Your Reference Committee heard overwhelmingly supportive testimony on Resolution 212, noting that the inclusion of this patient data in medical documentation is paramount to providing quality care to the LGBT community. Your Reference Committee therefore recommends amending Resolution 212 by including the reference to documentation in the electronic health record.

- (10) RESOLUTION 205 - AMA STUDY OF THE AFFORDABLE CARE ACT
 RESOLUTION 209 - AFFORDABLE CARE ACT REVISIT
 RESOLUTION 223 - EMERGENCY POST-ELECTION SUPPORT FOR PRINCIPLES OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
 RESOLUTION 224 - PROTECTING PATIENT ACCESS TO HEALTH INSURANCE AND AFFORDABLE CARE ACT
 RESOLUTION 226 - CONTINUING AMA ADVOCACY ON THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends adoption of the following resolution in lieu of Resolutions 205, 209, 223, 224, and 226:

PROTECTING PATIENT ACCESS TO HEALTH INSURANCE
 COVERAGE, PHYSICIANS, AND QUALITY HEALTH CARE

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA Board of Trustees report back to our AMA House of Delegates at the Annual 2017 Meeting (A-17).

HOD ACTION: Alternate resolution adopted in lieu of Resolutions 205, 209, 223, 224, and 226:

Resolution 205 asks that our American Medical Association study, and using our extensive HOD policy, identify what needs to be changed/fixed with the ACA; and be it further, and that our AMA compile a policy compendium of AMA HOD Policy or links to that policy, to provide to legislators, think tanks, and the public with reliable accurate ideas and knowledge; and be it further that a comprehensive report on how to change and improve the ACA be presented back to the House of Delegates at the 2017 Annual Meeting.

Resolution 209 asks that our American Medical Association House of Delegates no longer support the Affordable Care Act (ACA) in its current form and to work for replacement or substantial revision of the act to include these changes: 1) Allowing health insurance to be sold across state lines; 2) Allowing all businesses to self-insure and to purchase insurance through business health plans or association health plans; 3) Improving the individual mandate with a refundable tax credit that would be used to purchase health insurance; Improving health-related savings accounts so as to help ACA insureds afford their higher deductibles and co-pays; Reversing cuts to traditional Medicare and Medicare Advantage programs; Encouraging states to develop alternatives to Medicaid by using federal funds granted under provisions of the ACA; Eliminating all exemptions, loopholes, discounts, subsidies and other schemes to be fair to those who cannot access such breaks in their insurance costs (New HOD Policy); and be it further that our AMA maintain the following provisions to the ACA if it is replaced: 1) Full coverage of preventive services; 2) Family insurance coverage of children living in a household until age 26; 3) Elimination of lifetime benefit caps; and 4) Guaranteed insurability.

Resolution 223 asks that our American Medical Association make a public statement that any health care reform legislation considered by Congress ensure continued improvement in patient access to care and patient health insurance coverage by maintaining: 1) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, 2) Income-dependent tax credits to subsidize private health insurance for eligible patients, 3) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), 4) Maintaining dependents on family insurance plans until the age of 26, 5) Coverage for preventive health services, 6) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs. (Directive to Take Action)

Resolution 224 asks that our American Medical Association advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (1) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (2) Income-dependent tax credits to subsidize private health insurance for eligible patients, (3) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), (4) Maintaining dependents on family insurance plans until the age of 26, (5) Coverage for preventive health services, (6) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (7) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits. (New HOD Policy)

Resolution 226 asks that our American Medical Association actively and in a timely manner engage the new Administration in discussions about the future of the Patient Protection and Affordable Care Act, emphasizing our AMA's body of policy on health system reform. (Directive to Take Action)

Your Reference Committee heard very passionate testimony from many witnesses representing a wide range of opinions and perspectives from a broad mix of state, specialty, and regional delegations and sections, as well as individual physicians. Your Reference Committee agrees with comments that the recent presidential and congressional elections present our AMA with an opportunity to actively engage the new Administration and Congress in discussions about the future of health care reform. Your Reference Committee also heard substantial testimony in favor of AMA support of efforts to provide coverage for the uninsured and that our AMA should be a resource for policy makers and other stakeholders to advance health care insurance coverage. This testimony noted that our AMA has a strong foundation of existing policy on health system reform and coverage for the uninsured, including policy on the issues included in Resolutions 209, 223, and 224. Furthermore, your Reference Committee heard testimony from the Council on Medical Service (CMS) and the Council on Legislation that our AMA has conducted numerous studies on various health system reform provisions in the Affordable Care Act, including [CMS](#)

[Report 5-I-13](#), Monitoring the Affordable Care Act, and [CMS Report 9-A-14](#), Improving the Affordable Care Act. Therefore, your Reference Committee believes that additional policy or creation of a policy compendium called for in Resolutions 205, 209, 223, and 224 is not necessary at this time. Instead, your Reference Committee agrees with testimony that existing policy and reports are sufficient for our AMA to determine the best course of action in the new political environment, and that our AMA is well-positioned to be an effective advocate for advancing and improving upon the current health care system. Your Reference Committee also agrees with testimony that our AMA actively engage the new Administration and Congress in discussions about the future of health care reform, and collaborate with state and specialty medical societies. Furthermore, your Reference Committee heard testimony urging our AMA to move forward with a simple, clear statement communicating our message on health care reform, and recommending adoption of Resolution 226 along with the second and third resolves from a proposed amendment that would have revised Resolution 209. Your Reference Committee agrees with this approach and recommends adoption of a resolution that calls on our AMA to actively engage with the new Administration and Congress on the future of health care reform (based on our extensive AMA policy), collaborate with state and specialty medical societies, and craft a strong public statement articulating our commitment to our current AMA policy.

(11) RESOLUTION 208 - MIPS AND MACRA EXEMPTIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~support~~ advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and ~~Chip~~HIP Reauthorization Act of 2015 (MACRA) for small practices ~~since these rules will hasten the demise of small private practice in the U.S.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 adopted as amended.

Resolution 208 asks that our American Medical Association support an exemption from the merit-based incentive payment system (MIPS) and Medicare Access and Chip Reauthorization Act of 2015 (MACRA) for small practices since these rules will hasten the demise of small private practice in the U.S.

Your Reference Committee heard strong support for Resolution 208. Testimony noted concerns that participation in the Merit-Based Incentive Payment System (MIPS) poses challenges for small practices, and that our AMA should advocate for an exemption for small practices. We heard from multiple specialties with a large number of members in small practices that supported this resolution. We also heard testimony that the need for an exemption for small practices from MIPS was no longer necessary due to the recent release of the Quality Payment Program (QPP) final rule, which included a low-volume threshold that had been significantly increased. Other testimony argued that the low-volume threshold needs to be higher to exclude a greater number of practices. Some testimony supported the resolution, but noted that the low-volume threshold affects specialties differently. Testimony also noted that we have existing policy, D-390.949, which already supports an exemption for small practices under MIPS. Your Reference Committee also heard testimony and received amendments noting that the budget neutrality provisions of the QPP need to be reformed and that physicians nearing retirement should be exempted from the QPP. While your Reference Committee agrees that these are important issues to be considered, we believe that they go beyond the scope of this resolution. Finally, while your Reference Committee supports this resolution, we recommend the language referring to the demise of small practices in the U.S. should be removed. Supporting an exemption for small practices aligns with current AMA policy and was strongly supported by testimony; however, your Reference Committee has concerns that including the language regarding the demise of small private practice in Resolution

208 may actually impede our AMA's ability to successfully advocate for this policy. Your Reference Committee also recommends minor editorial amendments to the references to the Merit-Based Incentive Payment System (MIPS) and CHIP. Therefore, your Reference Committee recommends that Resolution 208 be adopted as amended.

(12) RESOLUTION 213 - SOAP NOTES AND CHIEF COMPLAINT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy D-320.991 be amended by addition and deletion to read as follows:

3) Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during an RAC audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered;

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy D-320.991 be adopted as amended in lieu of Resolution 213.

HOD ACTION: Policy D-320.991 adopted as amended in lieu of Resolution 213.

Resolution 213 asks that our American Medical Association amend AMA Policy D-320.991, Creating a Fair and Balanced Medicare and Medicaid RAC Program, by addition to read as follows: 1) Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices; 2) Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment; 3) Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during a RAC audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered; 4) Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors; 5) Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors; 6) Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians; 7) Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs; 8) Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

Your Reference Committee heard limited and supportive testimony on Resolution 213. Your Reference Committee strongly believes that the RAC program in the Medicare program is deeply flawed and has negatively impacted

individual physician practices despite the RACs' poor track record on appeals. Our AMA is well-positioned to provide information on lessons learned and shared strategies for addressing the Medicaid RAC programs. Your Reference Committee also supports the author's minor amendment that would broaden the scope of this Resolution by deleting the reference to RAC, and therefore, recommends that Resolution 213 be adopted as amended.

(13) RESOLUTION 215 - PARENTAL LEAVE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the First Resolve of Resolution 215 be amended by addition to read as follows:

RESOLVED, That our American Medical Association 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 reduction in the number of employees from 50 employees;
- an increase in the number of covered weeks from 12 weeks; and
- creating a new benefit of paid parental leave (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 215 be adopted as amended.

HOD ACTION: Resolution 215 adopted as amended.

Resolution 215 asks that our American Medical Association study 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 reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave; and be it further, that our AMA study the effects of FMLA expansion on physicians in varied practice environments.

Your Reference Committee heard mixed testimony on Resolution 215. Arguments in favor of the resolution noted that this issue has significant implications for the health of parents and infants alike and is worthy of AMA study accordingly. Testimony in favor also noted that paid leave allows parents to take longer leave and is associated with greater improvements in infant mortality compared to unpaid leave. Testimony also noted that longer use of parental leave improves health outcomes for the child by decreasing infant mortality, increasing the likelihood of the child having routine medical check-ups and being vaccinated, and increasing cognitive and behavioral scores in early childhood. Your Reference Committee also heard testimony that longer use of parental leave reduces the risk of maternal depressive symptoms and improves the physical health status of both mothers and fathers.

Testimony against adoption of this resolution noted that, at the 2016 Annual Meeting, the HOD approved Council on Medical Service (CMS) Report 3-A-16, which provided a comprehensive review of sick leave and paid leave policies, and adopted new policy (H-440.823) that recognizes the public health benefits of paid sick leave and other discretionary paid time off; supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome. Testimony further noted that in light of this new policy, the high fiscal note of implementing Resolution 215, and that this is primarily an employer issue, adoption may not be the best use of our AMA's limited resources.

Your Reference Committee believes that paid parental leave is an important issue and recognizes the benefits of paid parental leave for parents and their children. However, your Reference Committee also notes the high fiscal note to conduct the studies called for in Resolution 215 and acknowledges that paid parental leave is primarily an employer issue. Given that the Council on Medical Service (CMS) recently provided a comprehensive review relating to the first resolve, your Reference Committee recommends that going forward we encourage the study of health

implications among patients. Therefore, your Reference Committee amending the first resolve and adopting the second resolve.

(14) THE RIGHTS OF RESOLUTION 217 - PATIENTS, PROVIDERS AND FACILITIES TO CONTRACT FOR NON-COVERED SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Second Resolve of Resolution 217 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA engage in efforts to convince the CMS ~~to rescind the CMS guidance that bundled all blepharoptosis procedures with all functional and aesthetic aspects of blepharoplasty and to abstain from inappropriate bundling other in~~ situations in which functional and aesthetic considerations should be able to be considered separately (Directive to Take Action);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 217 be adopted as amended.

HOD ACTION: Resolution 217 adopted as amended.

Resolution 217 asks that our American Medical Association reaffirm Policy D-380.997 and any other applicable policies; and be it further that our AMA engage in efforts to convince the CMS to rescind the CMS guidance that bundled all blepharoptosis procedures with all functional and aesthetic aspects of blepharoplasty and to abstain from bundling other situations in which functional and aesthetic considerations should be able to be considered separately; and be it further that our AMA actively oppose further regulations that would interfere with the rights of patients, providers, and facilities to privately contract for non-covered services.

Your Reference Committee heard testimony in support of Resolution 217. Testimony noted that the recent policy issued by Centers for Medicare and Medicaid Services (CMS) regarding the bundling of blepharoptosis and blepharoplasty procedures have negatively affected physicians' ability to provide aesthetic surgical procedures requested by their patients. Testimony was also presented agreeing that our AMA should support the right of physicians and patients to privately contract for non-covered services. Moreover, testimony noted that our AMA has several resolutions supporting the right to privately contract which have already been adopted. While most testimony supported Resolution 217, a significant amount of testimony also addressed the impact these inappropriate bundling policies may have on other specialties and the dangerous precedent this may set for bundling other procedures. Other testimony noted the trend in medicine toward reduced patient choice. Therefore, your Reference Committee believes the second resolve should be expanded to include not only blepharoptosis and blepharoplasty procedures, but all situations in which CMS inappropriately bundles services in which functional and aesthetic considerations should be able to be considered separately.

(15) RESOLUTION 219 - PROTECT INDIVIDUALIZED COMPOUNDING IN PHYSICIANS' OFFICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends adoption of the following resolution in lieu of Resolution 219:

RESOLVED, That our American Medical Association ~~strongly request~~ advocate that the US Food and Drug Administration (FDA) remove physician offices and ambulatory surgery centers from its definition of a compounding facility.

HOD ACTION: Alternate resolution adopted as amended in lieu of Resolution 219.

Resolution 219 asks that our American Medical Association strongly request that the US Food and Drug Administration (FDA) withdraw its draft guidance “Insanitary Conditions at Compounding Facilities” and that no further action be taken by the agency until revisions to the USP Chapter <797> on Sterile Compounding, have been finalized; and be it further, that our AMA work with the US Congress to adopt legislation that would preserve physician office-based compounding as the practice of medicine and codify in law that physicians compounding medications in their offices for immediate or subsequent use in the management of their patients are not compounding facilities under the jurisdiction of the FDA.

Your Reference Committee heard mixed testimony on Resolution 219. Testimony focused on concerns that patients will be unable to receive needed medication if small-level in-office compounding is eliminated, and the significant impact the US Food and Drug Administration’s (FDA) draft guidance, *Insanitary Conditions at Compounding Facilities*, may have on the practice of medicine. Other testimony noted that none of the recent deaths from compounded drugs have resulted from in-office physician compounding on a small scale. Other testimony recommended referral for report given the complexity of this issue. In addition, we heard testimony from a USP representative that noted the release of USP Chapter 797 on Sterile Compounding may not be finalized for several years. Your Reference Committee also received a proposed amendment that would require our AMA to advocate for the removal of physicians’ offices from the definition of a compounding facility within the FDA draft guidance, *Insanitary Conditions at Compounding Facilities*. Your Reference Committee understands that there is pronounced frustration and concern that the FDA and Congress have not addressed the negative consequences to patient access and health outcomes of limiting in-office preparations of treatments. However, based on a majority of the testimony heard, your Reference Committee believes that a new resolution would more adequately cover the intent of those testifying. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended.

(16) RESOLUTION 222 - PROHIBITION OF CLINICAL DATA BLOCKING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Second Resolve of Resolution 222 be amended by deletion to read as follows:

~~RESOLVED, That our AMA advocate for the adoption of federal and state legislation and regulations to place strict limits on the fees imposed by electronic health record vendors for the implementation and ongoing use of data sharing interfaces. (New HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 222 be adopted as amended.

HOD ACTION: Resolution 222 adopted as amended.

Resolution 222 asks that our American Medical Association advocate for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data to non-affiliated physicians who participate in the care of shared patients, thereby interfering with the provision of optimal, safe and timely care; and be it further that our AMA advocate for the adoption of federal and state legislation and regulations to place strict limits on the fees imposed by electronic health record vendors for the implementation and ongoing use of data sharing interfaces.

Your Reference Committee heard mixed testimony on Resolution 222. Some testimony supported the resolution and agreed that practices such as information blocking and excessive charges for the transfer of information are directly antithetical to efficient interoperability and must be stopped. In addition, your Reference Committee heard testimony

that receipt of data from non-affiliated physicians is a problem when they participate in the care of the patient but are not on the same electronic health record system as other physicians providing care. Your Reference Committee also heard compelling testimony that our AMA already has policies covering clinical data blocking and limiting the fees imposed by electronic health record vendors for the implementation and ongoing use of data sharing interfaces. However, testimony was also presented that passing another similar resolution may emphasize the need for the elimination of data blocking in upcoming legislative efforts. Your Reference Committee reviewed existing AMA policy on the issues of information blocking and electronic health record vendors charging excessive fees for the transfer of information. Your Reference Committee believes the first resolve offers an addition to existing policy, as it asks our AMA to expand advocacy efforts to prohibit the blocking of clinical data to non-affiliated physicians who participate in the shared care of patients. The second resolve, however, is already addressed in existing AMA policies including D-478.972 and D-478-973. Accordingly, your Reference Committee recommends that Resolution 222 be amended by deletion and adopted.

- (17) RESOLUTION 206 - ADVOCACY AND STUDIES ON AFFORDABLE CARE ACT SECTION 1332

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 206 be referred.

HOD ACTION: Resolution 206 referred.

Resolution 206 asks that that our American Medical Association advocate that the “deficit-neutrality” component of the current HHS rule for Section 1332 waiver qualification be considered only on long-term, aggregate cost savings of states’ innovations as opposed to having costs during any particular year, including in initial “investment” years of a program, reduce the ultimate likelihood of waiver approval; and that our AMA study reforms that can be introduced under Section 1332 of the Affordable Care Act in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same.

Your Reference Committee heard extensive testimony on the need to refer Resolution 206. Given the current political environment and the complexity of issues raised by Resolution 206, your Reference Committee agrees. Your Reference Committee, therefore, recommends that Resolution 206 be referred.

- (18) RESOLUTION 207 - LIMITATION ON REPORTS BY INSURANCE CARRIERS TO THE NATIONAL PRACTITIONER DATA BANK UNRELATED TO PATIENT CARE
RESOLUTION 225 - LIMITATIONS ON REPORTS BY INSURANCE CARRIERS TO THE NATIONAL PRACTITIONER DATA BANK UNRELATED TO PATIENT CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 207 and 225 be referred.

HOD ACTION: Resolutions 207 not adopted and Resolution 225 adopted.

Resolution 207 asks that our American Medical Association formally request that the Health Resources and Services Administration (HRSA) clarify that reports of medical malpractice settlements by physicians are contingent upon treatment, the provision of or failure to provide healthcare services, of the plaintiff; and that our AMA formally request that HRSA audit the National Practitioner Data Bank (NPDB) for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity’s settlement of a claim that included the name of the physician in his/her administrative role at the entity; and that HSRA should be compelled to remove the name of any physician from the NPDB who was reported by a medical malpractice carrier

as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff.

Resolution 225 asks that our American Medical Association seek legislation and/or regulation that would require the Health Resources and Services Administration (HRSA) to clarify that reports to the National Practitioner Data Bank (NPDB) of medical malpractice settlements by physicians be limited to those cases in which the named physician was directly involved in the provision of or failure to provide healthcare services; and that our AMA seek legislation and/or regulation that would require HRSA to audit the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity's settlement of a claim that included the names of those physicians in their administrative roles at the entity; and that our AMA seek legislation and/or regulation that would require HRSA to remove reports from the NPDB of any physician who was reported as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff; and that our AMA provide a report to the House of Delegates at the 2017 Interim Meeting regarding our AMA's interactions with HRSA and detailing the actions taken or planned by HRSA to eliminate inappropriate reporting of physicians to the NPDB.

Your Reference Committee heard supportive testimony on Resolution 207 and Resolution 225. Your Reference Committee also heard not only that our AMA has existing policy and has advocated consistent with this resolution, but also that this policy and advocacy led to inclusion of the following language in the 2015 revision to the National Practitioner Data Bank (NPDB) guidebook: "Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner's provision of or failure to provide health care services." While your Reference Committee believes that the NPDB guidebook revisions have clarified some of the issues raised in Resolutions 207 and 225, there are situations in which reporting requirements are not clear, as testimony suggested.

These are important issues that warrant further study. Therefore, your Reference Committee recommends that Resolution 207 and Resolution 225 be referred.

(19) RESOLUTION 211 - ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-478.982 be reaffirmed in lieu of Resolution 211.

HOD ACTION: Policy D-478.982 reaffirmed in lieu of Resolution 211.

Resolution 211 asks that our American Medical Association support federal legislation that will replace current meaningful use with common sense meaningful use developed by the medical profession that is user friendly and practical.

Your Reference Committee heard supportive testimony on Resolution 211. However, your Reference Committee also heard testimony that current AMA policy captures the intent of this resolution. Specifically our AMA has policy stating that our AMA will work with the federal government and the Department of Health and Human Services to set realistic targets for the meaningful use of electronic health records and improve the electronic health records incentive program. We also heard testimony that given the recent release of the Quality Payment Program (QPP) final rule, which replaces the Meaningful Use incentive program with the Advancing Care Information beginning January 1, 2017, this resolution is no longer needed. In addition, we heard testimony in support of a resolution that would require our AMA to advocate to CMS that all EMR meet the AMA/Rand guidelines from the AMA/Rand white paper. Your Reference Committee believes that the intent of all the testimony is included in AMA's existing policies on electronic health records and the Meaningful Use incentive program. Therefore, your Reference Committee recommends that existing policies be reaffirmed in lieu of Resolution 211.

D-478.982 Redefine "Meaningful Use" of Electronic Health Records

Our AMA will work with the federal government and the Department of Health and Human Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry,

electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation. 2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare and Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria.

(20) RESOLUTION 221 - ELECTRONIC MEDICAL RECORDS RECOVERY FEES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-478.972 be reaffirmed in lieu of Resolution 221.

HOD ACTION: Policy D-478.972 reaffirmed in lieu of Resolution 221.

Resolution 221 asks that our American Medical Association work to create legislation to be introduced to the US Congress that would eliminate the costs to physicians associated with recovering patient health care records from a previous electronic medical records (EMRs) vendor, when they upgrade to a new EMR vendor.

Your Reference Committee heard mixed testimony on Resolution 221. Some who supported the Resolution argued that the prohibitive costs associated with recovering health care records from a previous electronic health record vendor significantly impact physicians, and that the inability to move patient records to a new system, prohibited physicians from changing electronic health record vendors. Testimony also noted that many physicians adopt an electronic health record system, and accept the initial cost; however, the costs continue to increase each year. Other testimony suggested that a penalty should be imposed on electronic health record vendors when they do not support interoperability. Some testimony suggested that this resolution should be expanded to include reporting to registries. Testimony also asked for clarification on whether the resolution would require an electronic health record vendor to provide data in a PDF format or in a more compatible, useful way, which may be significantly more costly. Finally, your Reference Committee heard compelling testimony that our AMA has extensive policies on data migration, data portability and reducing electronic health record costs for physicians. Specifically, existing AMA policy states that our AMA will support and encourage Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange. Accordingly, your Reference Committee recommends that policy D-478.972 be reaffirmed in lieu of Resolution 221.

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.

REPORT OF REFERENCE COMMITTEE C

(1) RESOLUTION 303 - PRIMARY CARE AND MENTAL HEALTH TRAINING IN RESIDENCY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 303 be adopted.

HOD ACTION: Original language of the first and second Resolves adopted as amended, to read as follows:

RESOLVED, That our American Medical Association advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care and ~~primary care services~~ to existing psychiatry, addiction medicine and primary care training programs' clinical settings (New HOD Policy); and be it further

RESOLVED, That our AMA encourage graduate medical education programs in primary care, and psychiatry, and addiction medicine ~~residency training programs~~ to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated ~~mental behavioral~~ health and primary care model, such as the collaborative care model (New HOD Policy); and be it further

Resolution 303 asks that our American Medical Association 1) advocate for the incorporation of integrated mental health and primary care services into existing psychiatry and primary care training programs' clinical settings; 2) encourage primary care and psychiatry residency training programs to create and expand opportunities for residents to obtain clinical experience working in an integrated mental health and primary care model, such as the collaborative care model; and 3) advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

Your Reference Committee heard overwhelming support for this resolution, which is backed by an abundance of existing AMA policy. Testimony was offered regarding the importance of integrated care models; the effects of appropriate reimbursement; reduction of health care costs; and access to care for patients in underserved areas. Statistics related to the overall number of Americans who experience mental illness in a given year also gave weight to the already unanimous testimony. Your Reference Committee therefore recommends that Resolution 303 be adopted.

(2) RESOLUTION 310 - MAINTENANCE OF CERTIFICATION AND INSURANCE PLAN PARTICIPATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 310 be adopted.

HOD ACTION: Resolution 310 adopted.

Resolution 310 asks that our American Medical Association increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

Your Reference Committee heard unanimous testimony in support of this resolution. It would be consistent with AMA policy to communicate with the insurance industry and request that MOC not become a requirement for insurance panel participation. Policy H-275.924 (15) states that "The MOC program should not be a mandated

requirement for licensure, credentialing, reimbursement, network participation, or employment.” Therefore, your Reference Committee recommends that Resolution 310 be adopted.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 1 - ACCESS TO CONFIDENTIAL HEALTH SERVICES FOR MEDICAL STUDENTS AND PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 1 be amended by addition and deletion, to read as follows:

1. That our American Medical Association (AMA) ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

1) Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including and mental health counseling services, that: a) include appropriate follow-up; b) are outside the trainees’ grading and evaluation pathways; and c) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Education Report 1 be amended by addition, to read as follows:

2. That our AMA urge state medical boards to refrain from asking applicants about past history of mental health diagnosis or treatment, and only focus on current impairment by mental illness, and to accept “safe haven” non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. (New HOD Policy).

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 1 be amended by the addition of a seventh Recommendation, to read as follows:

7. That our AMA encourage medical schools to create mental health awareness and suicide prevention screening programs that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administrative action, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) inform students and faculty about personal mental health and risk factors that may contribute to suicidal ideation. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendation 1 amended by addition and deletion, to read as follows:

1. That our American Medical Association (AMA) ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

1) Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including and mental health and substance use disorder counseling services, that: a) include appropriate follow-up; b) are outside the trainees' grading and evaluation pathways; and c) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

Recommendation 2 amended by addition, to read as follows:

2. That our AMA urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure 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. (New HOD Policy).

CME Report 1 amended by the addition of a seventh Recommendation, to read as follows:

7. That our AMA encourage medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administrative action, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. (Directive to Take Action)

Council on Medical Education Report 1 asks 1) that our American Medical Association (AMA) ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to: (1) Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care and mental health counseling services that: a) include appropriate follow-up; b) are outside the trainees' grading and evaluation pathways; and c) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means; (2) Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical

health of trainees; (3) Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and (4) Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2) That our AMA urge state medical boards to accept “safe haven” non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3) That Policy H-345.973, “Mental Health Services for Medical Students and Resident and Fellow Physicians,” be amended by addition and deletion, as follows. Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians

Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.

4) That Policy H-295.872, “Expansion of Student Health Services,” be rescinded, as it is (in part) already reflected in current LCME standards and (in part) now incorporated into Policy H-345.973, Mental Health Services for Medical Students and Resident and Fellow Physicians.

5) That Policy D-405.992, “Physician Health and Wellness,” and D-405.996, “Physician Well-Being and Renewal,” be rescinded, as these directives have been accomplished, are superseded by other policy, or are no longer relevant.

6) That Policy D-405.983, “Medical Students and Residents as Patients,” be rescinded, as having been fulfilled by this report.

Your Reference Committee heard strong testimony in support of a well-written report by the Council on Medical Education. It was noted that resident/fellow physicians all too often forego their own health needs, due to their busy schedules and devotion to their patients and their ongoing education. In addition, concern over potential future career and medical licensure implications can inhibit attention to mental health needs. Such inattention, over the long term, compounded by the many stresses of residency education, can contribute to the development of mental health issues and physician suicide. This report offers concrete steps to address these concerns. Friendly amendments to enhance the report included a suggestion not to differentiate between health services and mental health services (through insertion of “including,” rather than “and”); revised language to ensure that state medical boards focus only on current health impairment; and a new recommendation to urge a more proactive approach by medical schools to create effective mental health awareness and suicide prevention screening programs. Your Reference Committee believes these changes strengthen this report, and urges adoption as amended.

(4) RESOLUTION 301 - EXPANDING THE TREATMENT OF OPIATE DEPENDENCE USING MEDICATION-ASSISTED TREATMENT BY PHYSICIANS IN RESIDENCY TRAINING PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 301 be amended by deletion, to read as follows:

RESOLVED, That our American Medical Association encourage the expansion of residency and fellowship training opportunities to provide clinical experience in the ~~medication-assisted~~ treatment of opioid use disorders, under the

supervision of an appropriately trained physician (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 301 be amended by deletion, to read as follows:

RESOLVED, That our AMA support additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the ~~medication-assisted~~ treatment of opioid use disorders. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 301 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 301 be changed, to read as follows:

IMPROVING RESIDENCY TRAINING IN THE TREATMENT OF OPIOID DEPENDENCE

HOD ACTION: Resolution 301 adopted as amended with a change in title.

Resolution 301 asks that our American Medical Association 1) encourage the expansion of residency and fellowship training opportunities to provide clinical experience in the medication-assisted treatment of opioid use disorders, under the supervision of an appropriately trained physician; and 2) support additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the medication-assisted treatment of opioid use disorders.

Your Reference Committee heard extensive testimony in support of this resolution, which takes steps to help learners address the opioid epidemic in the United States in a manner that encourages educational opportunities but does not impose curricular mandates. Testimony also noted that this resolution is aligned with existing AMA policy, which calls for increased funding for graduate medical education. It was proposed that the resolution be broadened to include training opportunities for all types of addictive disease, not only opioid use disorders, especially given a comparison of opioid-related morbidity and mortality with alcohol- and tobacco-related morbidity and mortality. While an important observation, substantial testimony guided your Reference Committee to the conclusion that the intent of this resolution was specific to the opioid crisis, and that maintaining this strict focus would better assist the AMA to reach related policy goals and address specific financial barriers. Your Reference Committee did feel, however, that removing the phrase “medication assisted” from both resolved clauses and the title would strengthen the overall intent. Your Reference Committee therefore recommends that Resolution 301 be adopted as amended.

(5) RESOLUTION 302 - PROTECTING THE RIGHTS OF BREASTFEEDING RESIDENTS AND FELLOWS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 302 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to

~~mandate~~ include language in housestaff manuals or similar policy references of all training programs ~~on the~~ regarding protected times and locations for milk expression and secure storage of breast milk (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 302 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with appropriate bodies, such as the ~~ACGME~~ Liaison Committee for Medical Education (LCME), Accreditation Council for Graduate Medical Education (ACGME), and ~~the~~ Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breast-feeding mothers in regular program reviews. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 302 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 302 be changed, to read as follows:

PROTECTING TRAINEES' BREAST-FEEDING RIGHTS

HOD ACTION: Resolution 302 adopted as amended with a change in title.

Resolution 302 asks that our American Medical Association 1) work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME), to mandate language in housestaff manuals or similar policy references of all training programs on the protected time and locations for milk expression and storage of breast milk; and 2) work with appropriate bodies, such as the ACGME and the Association of American Medical Colleges, to include language related to the learning and work environments for breast feeding mothers in regular program reviews.

Your Reference Committee heard universally strong support from multiple constituencies for this Resolution, with the acknowledgment that it would be paradoxical for our AMA to support protected time and locations for expression and storage of breast milk in the general public and practicing physician population without corresponding support for these rights for physician trainees. Testimony was heard that favored expanding the language of this resolution to include all medical students, residents, fellows, and practicing physicians. However, your Reference Committee felt that the intention of this resolution was to give a voice to those in training who are less able to effect meaningful change in their immediate work environments. For this reason, your Reference Committee felt it was appropriate to add the Liaison Committee for Medical Education (LCME) to both resolved clauses and extend the policy to all trainees, but not to address the practicing physician population. A subsequent change to the title of the Resolution is also therefore necessary. Additional testimony, felt to be constructive by your Reference Committee, requested that the first resolve be clarified to specify the provision of secure storage options for expressed breast milk. Your Reference Committee is acutely aware that smaller practices with fewer resources and those in certain settings may struggle to achieve these standards. However, your Reference Committee feels that it is the obligation of each residency program to take breast-feeding trainees' needs into account when scheduling rotations, ensuring these trainees are not forced to jeopardize their training, their personal health, or the health of their children. For these reasons, your Reference Committee recommends that Resolution 302 be adopted as amended.

(6) RESOLUTION 304 - IMPROVING ACCESS TO CARE AND HEALTH OUTCOMES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 304 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~support~~ encourage training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 304 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 304 be changed, to read as follows:

IMPROVING CULTURAL COMPETENCY TRAINING OPPORTUNITIES

HOD ACTION: Resolution 304 be adopted as amended with a change in title.

Resolution 304 asks that our American Medical Association support training opportunities for students and residents to learn cultural competency from community health workers.

Your Reference Committee heard testimony in support for Resolution 304. The authors of the resolution noted that this would expand existing AMA policy in support of these workers in health care practice by supporting and recognizing the value of community health workers as key educational adjuncts, as resident/fellow physicians learn about the many ways that community dynamics contribute to (or detract from) an individual's health and well-being. Recognizing the potential burden of the growing number of requirements and educational mandates on both trainees and programs/teaching hospitals, an amendment was proffered to ensure that such education be provided only if it could be integrated into existing rotations. It was also noted that the importance of the physician-led team should be emphasized, as reflected in existing AMA policy. Finally, we believe that a title change is warranted, to ensure that this potential policy is in accord with its contents. Accordingly, your Reference Committee recommends adoption of Resolution 304 as amended.

(7) RESOLUTION 305 - PRIVACY, PERSONAL USE AND FUNDING OF MOBILE DEVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association encourage further research ~~in~~ integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that second Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure a more uniform regulation for use of mobile devices in medical education and clinical training (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that third Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA encourage medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines ~~in~~ for using personal mobile devices in clinical environments. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 adopted as amended.

Resolution 305 asks that our American Medical Association 1) encourage further research in integrating mobile devices in clinical care, particularly to address challenges of reducing work burden while maintain clinical autonomy for residents and fellows; 2) collaborate with the Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure a more uniform regulation of mobile devices in medical education and clinical training; and 3) encourage medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines in using personal devices in clinical environment.

Your Reference Committee heard mixed testimony on this item, but all who testified, both online and in person, agreed that the subject of this resolution is one of critical and growing importance. Some sentiment was expressed for referral, but your Reference Committee believes that our AMA is best served by passing policy immediately versus waiting 12 to 18 months for drafting and development of a Board or Council report—particularly in an area where change is constant and continuous. Furthermore, work on this and related topics is ongoing by the AMA's Professional Satisfaction and Practice Sustainability (PS2) strategic focus area. The authors noted the growing use of mobile phones in health care settings, especially among resident/fellow physicians, and the need for AMA policy in this regard. The resolution covers a number of key issues, both technological and legal, including data privacy, infection control, costs, and professionalism. This is a well-researched resolution, with numerous citations from the literature on this topic. Going forward, investigation into the HIPAA implications of such devices in clinical settings would be warranted; the AMA (through its PS2 focus area) could help to support and/or encourage such work. Therefore, with the minor edits shown, and the addition of the Liaison Committee on Medical Education in the second resolve, your Reference Committee recommends adoption as amended.

(8) RESOLUTION 306 - FORMAL LEADERSHIP TRAINING DURING MEDICAL EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 306 be amended by substitution, to read as follows:

RESOLVED, That our American Medical Association advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 306 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA advocate for and support the creation of programs and curricula to develop the leadership competencies and foundational skills for medical practitioners necessary to effectively understand and navigate current and future policy changes from the Center for Medicare and Medicaid Services, while continuing to maintain said practitioners fiduciary responsibility and high-quality patient care (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 306 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership capabilities; so that all doctors obtain a minimum standard of leadership and management skills. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended.

Resolution 306 asks that our American Medical Association 1) advocate for and support the creation of programs and curricula that emphasize experiential and active learning models which are inclusive of leadership knowledge, skills and the qualities utilized in the clinical setting through direct observation and which foster a shared learning environment with the entire interdisciplinary care team; 2) advocate for and support the creation of programs and curricula to develop the leadership competencies and foundational skills for medical practitioners necessary to effectively understand and navigate current and future policy changes from the Center for Medicare and Medicaid Services, while continuing to maintain said practitioners fiduciary responsibility and high-quality patient care; and 3) advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical

training to promote the development of leadership capabilities, so that all doctors obtain a minimum standard of leadership and management skills.

Your Reference Committee heard wide-ranging testimony that was supportive of the intent of the resolution. Consensus was heard regarding the importance of leadership training, and it was agreed that introducing such training earlier in one's career, rather than later, was a laudable and important goal. Leadership training was acknowledged to be important for all learners regardless of ultimate career path. Testimony further elucidated the connection between training that enhances leadership skills and the AMA's strategic goal of modernizing medical education. Leadership skills were recognized as a skill set that will be necessary to succeed in the health care environment of the future. Testimony also noted the strong work the AMA is already offering related to leadership via the Accelerating Change in Medical Education initiative, programming offered by member sections, the AMA's Professional Satisfaction and Practice Sustainability (PS2) initiative, and a partnership with the American Association for Physician Leadership. Valid concerns were raised that while the intention of the resolution is commendable, it could, as written, further promote siloed training. Different models of leadership, including those utilized in other disciplines, hold promise for study and potential adaptation by and for physicians. Partnerships with non-physicians also will be imperative in these endeavors. Your Reference Committee agrees that the topic of formal leadership training is important and timely, and believes that future resolutions may wish to address leadership training for practicing physicians. However, this resolution was understood to address training in medical education, where concerns and competencies are quite different from those expected of practicing physicians. Therefore, your Reference Committee recommends that Resolution 306 be adopted as amended.

- (9) RESOLUTION 307 - INAPPROPRIATE USES OF MAINTENANCE OF CERTIFICATION
RESOLUTION 311 – PREVENT MAINTENANCE OF CERTIFICATION
LICENSURE AND HOSPITAL PRIVILEGING REQUIREMENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 307 and 311.

RESTRICTIONS ON THE USE OF MAINTENANCE OF CERTIFICATION
RESOLVED, That our American Medical Association, through legislative, regulatory, and collaborative efforts, work with interested state medical societies to advocate that Maintenance of Certification not be a requirement for: (1) medical staff membership, privileging, credentialing, or recredentialing; (2) insurance panel participation; or (3) state medical licensure. (Directive to Take Action)

RESOLVED, That our AMA amend Policy H-275.924, "Maintenance of Certification," Bullet No. 15, by addition and deletion, to read as follows:

15. The MOC program should not be a mandated requirement for licensure, credentialing, rec credentialing, privileging, reimbursement, network participation, ~~or employment~~, or insurance panel participation. (Modify Current HOD Policy)

HOD ACTION: Alternate resolution adopted in lieu of Resolutions 307 and 311; Resolve 1 amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association, through legislative, regulatory, ~~and or~~ collaborative efforts, work with interested state medical societies and other interested parties to advocate by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for:

(1) medical staff membership, privileging, credentialing, or recredentialing; (2) insurance panel participation; or (3) state medical licensure. (Directive to Take Action)

Resolution 307 asks that our American Medical Association, through legislative, regulatory, and collaborative efforts, advocate that Maintenance of Certification not be a requirement for: (1) medical staff membership, privileging, or credentialing; (2) insurance panel participation; or (3) state medical licensure.

Resolution 311 asks that our American Medical Association, 1) consistent with Policy H-275.924, vigorously advocate by legislation, regulation, or other appropriate activity to prevent the use of maintenance of certification as a licensing requirement in any state; and 2) amend Policy H-275.924, "Maintenance of Certification," Bullet No. 15, by addition to read as follows:

15. The MOC program should not be a mandated requirement for licensure, credentialing, hospital privileging, reimbursement, network participation or employment.

Your Reference Committee heard testimony in support of Resolutions 307 and 311. It was noted that maintenance of certification (MOC) in its current form continues to be a burden to some physicians participating in the program. Although some of the American Board of Medical Specialties member boards are making considerable progress in redesigning their MOC programs to make them relevant to practicing physicians and their patients due to physician input, it was felt that participation should not be linked to credentialing, licensing, and reimbursement processes as a general matter. During the testimony, it was also noted that professional self-regulation should not involve legislation and that it is inappropriate to ask hospitals and insurers to consider other factors in place of MOC during their credentialing processes. The AMA has adopted extensive policy on MOC and supports the intent of this program. In addition, your Reference Committee believes that the primary concern in both of these resolutions—that MOC not be a mandated requirement for state licensure, privileges, credentialing, recredentialing, reimbursement, network participation/insurance panel participation, or employment—could be satisfied by amending current AMA policy to add those circumstances not currently listed in policy. For these reasons, your Reference Committee carefully and deliberately considered this testimony and recommends adoption of the proposed resolution in lieu of the original items.

(10) RESOLUTION 309 - DEVELOPMENT OF ALTERNATIVE COMPETENCY ASSESSMENT MODELS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 309 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association amend Policy H-275.936, Mechanisms to Measure Physician Competency, by addition and deletion to read as follows:

Our AMA (1) continues to work with the American College of Graduate Medical Education, American Board of Medical Specialties, and other relevant organizations to develop, explore alternative and more accurate evidence-based methods to of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and ~~(2)~~(3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 309 be adopted as amended.

HOD ACTION: Resolution 309 adopted as amended.

Resolution 309 asks that our American Medical Association amend AMA Policy H-275.936, Mechanisms to Measure Physician Competency, by addition and deletion to read as follows:

Our AMA (1) works with the American College of Graduate Medical Education, American Board of Medical Specialties, and other relevant organizations to develop alternative and more accurate methods to determine ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and ~~(2)~~(3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.

Your Reference Committee heard testimony in support of Resolution 309. There was strong support for the Council on Medical Education's recommendation to amend the first part of policy H-275.936 because the purview of the Accreditation Council for Graduate Medical Education is limited to physicians in residency training, not to the clinical competency of practicing physicians for certification and recertification. The Council has ongoing work with the American Board of Medical Specialties relating to competency assessment, which will continue with regular meetings with their leadership. For example, a session with the leadership of the 24 ABMS member boards is being planned for June 2017, to discuss innovative solutions to comply with Maintenance of Certification Part IV (similar to the forum held on Part III in June of 2014). While our AMA might explore existing and alternative methods for determining clinical competency, it is not the AMA's role to develop such methods/models across multiple specialties and subspecialties. For these reasons, your Reference Committee recommends that Resolution 309 be adopted as amended.

(11) RESOLUTION 312 - ELIMINATING THE TAX LIABILITY FOR PAYMENT OF STUDENT LOANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 312 be amended by addition and deletion, to read as follows:

RESOLVED, that our American Medical Association ~~work with the Internal Revenue Service to support~~ eliminate ~~ion of~~ the tax liability when ~~private~~ employers provide the funds to repay student loans for physicians who agree to work in an underserved area. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 312 be adopted as amended.

HOD ACTION: Resolution 312 adopted as amended.

Resolution 312 asks that our American Medical Association work with the Internal Revenue Service to eliminate the tax liability when private employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

Your Reference Committee heard testimony in support of viable solutions to the growing and onerous debt burden on medical students—a burden that continues to increase. With medical students facing an average of more than \$170,000 in medical school debt, this item offers a win-win, by offering a financial carrot in exchange for vitally

needed health care services in underserved areas—many of which cannot offer competitive salaries in comparison to the more remunerative geographic areas of the country. Two amendments were proffered: One, to remove the IRS, as that agency does not have jurisdiction over setting tax regulations (that is the purview of Congress); and two, to extend this to any loan forgiveness program—not just those at private institutions. With these amendments, your Reference Committee urges adoption.

(12) RESOLUTION 308 - PROMOTING AND REAFFIRMING DOMESTIC MEDICAL SCHOOL CLERKSHIP EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 308 be referred.

HOD ACTION: Resolution 308 referred.

Resolution 308 asks that our American Medical Association 1) pursue legislative and/or regulatory avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition amongst medical schools and prevent unnecessary increases in domestically-trained medical student debt; 2) support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and 3) reaffirm policies D-295.320, D-295.931, and D-295.937.

Your Reference Committee heard unanimous testimony in support of referral of Resolution 308. This is a complex issue, with numerous factors, ranging from state law to physician workforce implications. The Council on Medical Education is well-suited to develop an in-depth, nuanced solution, one that involves all key stakeholders and places patient care and education needs at the forefront. To ensure an adequate opportunity for the necessary review and data gathering phase, your Reference Committee would recommend that this report be scheduled for the 2017 Interim Meeting (or later). We therefore recommend that Resolution 308 be referred.

REPORT OF REFERENCE COMMITTEE F

(1) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in the Report of the House of Delegates Committee on the Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Report of the House of Delegates Committee on the Compensation of the Officers adopted.

The Report of the House of Delegates Committee on Compensation of the Officers recommends: That there be no change to the current Definitions effective July 1, 2012 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for External Representation and Telephonic Per Diem for External Representation except for the Governance Honorarium and Per Diem amounts as recommended in 2, 3 and 4 below.

- Definition of Governance Honorarium effective July 1, 2012:
The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted above.
- Definition of Per Diem for Representation effective July 1, 2012:
The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel for Officers, excluding Board Chairs and Presidents. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/ partnering/facilitating achievement of the respective organizational goals such as the AMA Foundation, PCPI, etc. The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather related travel delays.
- Definition of Telephonic Per Diem for External Representation effective July 1, 2011:
Officers, excluding the Board Chairs and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments, receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equals two or more hours. Payment for these meetings requires approval of the Chair of the Board.
 1. That the Governance Honorarium for all Board members excluding leadership, Board Chair, Board Chair-elect, President, President-elect, and Immediate Past President be increased effective July 1, 2017 to \$65,000. (Directive to Take Action)
 2. That the Per Diem for Chair-assigned representation external to the AMA or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organizational goals such as the AMA Foundation, PCPI, etc., and related travel be increased effective July 1, 2017 to \$1,300 per day. (Directive to Take Action)
 3. That the Per Diem for Chair-assigned Telephonic Per Diem for External Representation be increased effective July 1, 2017 to \$650 as defined. (Directive to Take Action)
 4. Except as noted above, there be no other changes to the Officers compensation for the period beginning July 1, 2017. (Directive to Take Action)

Your Reference Committee received no testimony in opposition to the report. Additionally, your Reference Committee believes that the proposed increases for each of the 16 non-leadership Officers of our AMA Board of Trustees are modest and deserved given their increasing representation of our AMA and that there have been no changes in the compensation categories referenced since 2012.

- (2) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT
1 - MINORITY AFFAIRS SECTION AND INTEGRATED PHYSICIAN
PRACTICE SECTION, FIVE-YEAR REVIEWS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

**HOD ACTION: Council on Long Range Planning and Development Report 1
adopted.**

The Council on Long Range Planning and Development Report 1 recommends that our AMA renew delineated section status for the Minority Affairs Section and the Integrated Physician Practice Section through 2021 with the next review no later than the 2021 Interim Meeting.

Your Reference Committee received no negative testimony in response to the Council's report. Your Reference Committee appreciates the cooperation of both the Minority Affairs Section and the Integrated Physician Practice Section, which allowed the Council to present a thorough review of the delineated section status for both constituency groups. Your Reference Committee supports the recommendation of the Council.

- (3) RESOLUTION 606 - PROMOTE TEEN HEALTH WEEK

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 606 be adopted.

HOD ACTION: Resolution 606 adopted.

Resolution 606 calls upon our AMA to actively promote Teen Health Week 2017 and encourage state medical associations and specialty medical associations across the nation to join the initial efforts begun in Pennsylvania, and encourage schools and other appropriate organizations to adopt, promote, and participate in Teen Health Week.

Resolution 606 further calls upon our AMA to actively advocate, through direct communication with the appropriate agencies and organizations, for the development of an annually recognized Teen Health Week.

Your Reference Committee heard testimony favoring adoption of this resolution.

Testimony pointed out that adolescents have special health needs not applicable to either pediatric or adult patients. Good health habits formed in adolescence carry over into adulthood. Adolescence is an important time-limited opportunity to positively affect behaviors that contribute to chronic illness, unintended pregnancy, injury, and addiction.

Current AMA policy supports physician involvement in improving teen health. Your Reference Committee agrees that observing and promoting Teen Health Week nationally may benefit adolescent health.

(4) RESOLUTION 603 - SUPPORT A STUDY ON THE MINIMUM COMPETENCIES AND SCOPE OF MEDICAL SCRIBE UTILIZATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 603 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~partner with The Joint Commission and other stakeholders to study the minimum skills and competencies required of a medical scribe regarding documentation performance and clinical boundaries of~~ study medical scribe utilization in various health care settings. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 603 be adopted as amended.

HOD ACTION: Resolution 603 adopted as amended.

Resolution 603 calls upon our AMA to partner with The Joint Commission and other stakeholders to study the minimum skills and competencies required of a medical scribe, including but not limited to documentation performance and clinical boundaries of medical scribe utilization.

Your Reference Committee received testimony that was predominately opposed to Resolution 603. Physicians are ultimately responsible for all patient medical records whether or not medical scribes are utilized. Additionally, testimony reflected that the study described specifically by the resolution could lead to onerous regulations being imposed upon physicians' use of medical scribes, which may be more likely to occur in some areas of the country.

Current research suggests that medical scribe utilization is increasing significantly; that the use of medical scribes and their functions vary among medical specialties; and that employment decisions regarding medical scribe utilization differ among types of physician practices. For these reasons, your Reference Committee believes there is value in our AMA compiling data in order to better understand current medical scribe utilization and their roles in various health care settings.

(5) RESOLUTION 604 - OPPOSE PHYSICIAN GUN GAG RULE POLICY BY TAKING OUR AMA BUSINESS ELSEWHERE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 604 be referred.

HOD ACTION: Resolution 604 referred.

Resolution 604 calls upon our AMA to adopt policy that bars our AMA from holding House of Delegates meetings in states that enact physician gun gag rule laws.

Resolution 604 further calls upon our AMA to contact governors and convention bureaus of states that have enacted physician gun gag rules and inform them that our AMA will no longer hold House of Delegates meetings in their state, until the restrictive physician gun gag rule is repealed or struck down by the courts.

Your Reference Committee heard uniformly supportive testimony for promoting existing policy on our AMA's opposition to physician gag rules of any kind. Testimony varied as to whether or not our AMA should refuse to hold its meetings in states in which gun gag rules have been enacted. Those in favor believed our AMA should act in

accordance with adopted policy and uphold the core tenets of the patient-physician relationship. Some who were opposed believed that boycotts are polarizing and that our efforts could better be spent educating the public about the harmful effects of gag rules. Still others pointed out that a boycott will not result in any meaningful impact, as current laws and regulations may change in the future.

Your Reference Committee received testimony to suggest that tying meeting venue selection to a particular issue is a slippery slope that could be linked in the future to other issues.

Your Reference Committee agrees that our AMA policy opposing gag rules is appropriate and should be promoted, especially in states that have enacted gun gag rules. Your Reference Committee also believes that it is impossible to predict if state laws might change in the future, and that since our AMA meetings are complex events that must be contracted many years ahead, very little effective impact would be realized from a state boycott. Your Reference Committee recommends study to examine the issue fully.

(6) RESOLUTION 602 - EQUALITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 602 be referred.

HOD ACTION: Resolution 602 referred.

Resolution 602 calls for all future meetings and conferences organized and/or sponsored by our AMA, not yet contracted, to be held in towns, cities, counties, and states that do not have discriminatory policies based on race, color, religion, ethnic origin, national origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age.

Your Reference Committee received divided testimony in response to Resolution 602, which is attributable to the complex nature of the resolution. On the one hand, all agreed that exclusionary and discriminatory policies and practices that deny basic human rights are unacceptable; however, how to respond properly can be polarizing.

Because our AMA negotiates meeting contracts years in advance subject to cancellation penalties, a town, city, county, and/or state that is in harmony with our AMA's policy on discrimination could potentially have a changed position by the time our AMA intends to utilize the contracted venue in that territory. Conversely, a town, city, county, and/or state that was overlooked intentionally because of its exclusionary policies could have favorably amended its laws or ordinances.

Current AMA Policy G-630.140, "Lodging, Meeting Venues, and Social Functions" states that our AMA opposes exclusionary policies based on gender, race, color, religion, national origin, gender identity, or sexual orientation. Resolution 602 identifies some of these same classes while adding ethnic origin, language, creed, sex, gender expression, disability, and age. Your Reference Committee offers that while a combined list is more extensive, our AMA policy would still have failed to identify the additional classes of potential discrimination: pregnancy, parental status, employment, marital status, physical features, political belief or activity, personal association, and veteran status.

Additionally, a process/procedure needs to be vetted internally to ensure we do not restrict our AMA's business decisions with regard to meeting venues in unproductive or costly ways.

Due to the complex issues surrounding Resolution 602, your Reference Committee recommends referral of this item so a potential recommendation to amend current AMA policy can appropriately reflect our AMA's opposition to all forms of exclusionary or discriminatory policies or practices.

(7) RESOLUTION 607 - ANALYSIS OF AMERICAN BOARD OF INTERNAL MEDICINE (ABIM) FINANCES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 607 be referred for decision.

HOD ACTION: Resolution 607 adopted as amended.

RESOLVED, That our American Medical Association, prior to the end of December 2016, formally, directly and openly ask the American Board of Internal Medicine (ABIM) if they would allow an independent outside organization, representing ABIM physician stakeholders, to independently conduct an open audit of the finances of both the American Board of Internal Medicine (ABIM), a 501(c)(3) tax-exempt, non-profit organization, and its Foundation (Directive to Take Action); and be it further

RESOLVED, That in its request, our AMA seek a formal and rapid reply from the ABIM so that issues of concern that currently exist between the ABIM and its Foundation and many members of the AMA and the physician community at large can be addressed in a timely, effective and efficient fashion (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association (AMA) share the response to this request, as well as the results of any subsequent analysis with our AMA House of Delegates and our membership at large as soon as it is available. (Directive to Take Action); and be it further

RESOLVED, That the AMA call on the American Board of Medical Specialties and its component specialty boards to provide the physicians of America with financial transparency, independent financial audits and enhanced mechanisms for communication with and feedback from their diplomate physicians (Directive to Take Action).

Resolution 607 calls upon our AMA to formally, directly, and openly ask the American Board of Internal Medicine (ABIM), prior to the end of December 2016, to allow an independent outside organization, representing ABIM physician stakeholders, to independently conduct an open audit of the finances of both the American Board of Internal Medicine (ABIM), a 501(c)(3) tax-exempt, non-profit organization, and its Foundation.

Resolution 607 also calls upon our AMA to seek a formal and rapid reply from the ABIM so issues of concern that currently exist between the ABIM and its Foundation and many members of the AMA and the physician community at large can be addressed in a timely, effective and efficient fashion.

Finally, Resolution 607 calls upon our AMA to share the response to this request, as well as the results of any subsequent analysis with our AMA House of Delegates and our membership at large as soon as it is available.

Your Reference Committee heard mostly supportive testimony for this resolution. Those supporting it indicated that our AMA needs to speak up for its many members who are directly affected by the financial practices of the American Board of Internal Medicine's (ABIM) certification and maintenance of certification (MOC) practices, as Board certification is not an optional expense for many physicians. While good faith efforts have been made to shed light on these practices, so far individual physician voices have not been heard, and it was expressed that the ABIM has not been held accountable to its diplomates.

Those opposed to the resolution believe that our AMA should not interfere in another organization's business, and that recent successfully completed audits of ABIM do not show deviation from accepted accounting practices. It was

also pointed out that leadership at the ABIM has changed and that they need time to put new practices and procedures in place.

Your Reference Committee agrees that our AMA should advocate for its members who are concerned about excessive MOC fees that are not controllable. Your Reference Committee also agrees that our AMA needs to take a firm stand to support transparency in certification and MOC fees charged by all certifying boards, not just the ABIM. All certifying boards need to be held accountable to their diplomates.

Your Reference Committee believes that the preponderance of testimony was related to ethical practices by ABIM management, and that completing yet another financial audit, as requested by Resolution 607, will not address these ethical concerns. Also, your Reference Committee believes that adopting a specific policy about an affiliated medical organization that will remain in our AMA's body of policy for at least ten years does not serve our AMA well.

After carefully considering all testimony, your Reference Committee recommends that the resolution be referred to our AMA Board of Trustees for decision. This course of action will allow our Board of Trustees to act expeditiously, addressing the concerns expressed during testimony in a manner that best serves our AMA and our Federation members.

REPORT OF REFERENCE COMMITTEE J

(1) COUNCIL ON MEDICAL SERVICE REPORT 1 - INFERTILITY BENEFITS FOR VETERANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 1 adopted.

Council on Medical Service 1 recommends that our AMA support lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; encourage interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries; encourage the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process; and support efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

Testimony on Council on Medical Service Report 1 was unanimously supportive. A member of the Council introduced the report and stated that, while legislation adopted in October 2016 allowing the VA to cover IVF costs for the next two years is a step in the right direction, this legislation only lasts for two years and does not lift the ban. The representative from the Veterans Health Administration (VHA) testified that the VHA is working hard to implement this new legislation. Accordingly, your Reference Committee recommends that Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 3 - PROVIDERS AND THE ANNUAL WELLNESS VISIT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 3 adopted.

Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-425.997 and H-160.921; support that the Medicare Annual Wellness Visit (AWV) is a benefit most appropriately provided by a physician or a member of a physician-led health care team that establishes or continues to provide ongoing continuity of care; support that, at a minimum, any clinician performing the AWV must enumerate all relevant findings from the visit and make provisions for all appropriate follow-up care; support that the Centers for Medicare & Medicaid Services (CMS) provide a means for physicians to determine whether or not Medicare has already paid for an AWV for a patient in the past 12 months; and encourage CMS to educate Medicare enrollees, that, in choosing their primary care physician, they are encouraged to make their AWVs with their primary care physician in order to facilitate continuity and coordination of their care.

Testimony on Council on Medical Service Report 3 was supportive. A member of the Council introduced the report emphasizing continuity of care and supporting the principles that preventive care should be coordinated by the physician and physician-led team. Your Reference Committee received a number of suggested amendments. One speaker suggested that Recommendations 3 and 6 reference not a physician-led health care team but rather a physician-led patient-centered medical home. In response, a number of speakers noted that not all physicians and

patients are a part of a medical home. Your Reference Committee concurs and notes that a physician-led health care team already encompasses a physician-led patient-centered medical home. Another speaker suggested deletion of Recommendation 4. The recommendation requests that the clinician performing the AWV enumerate all relevant findings. However, as a member of the Council on Medical Service noted, because the statute allows for other clinicians to perform the AWV, Recommendation 4 acknowledges that reality and tries to work within those bounds. Your Reference Committee notes that this recommendation serves to not only hold all clinicians accountable for recording and follow-up care similar to the requirements put on physicians but also aims to mitigate disruptions in continuity of care. So although your Reference Committee appreciates the intent of that suggestion, in light of the current statute, your Reference Committee agrees with the Council's testimony.

Similarly, there was a suggestion to request that CMS not reimburse for the AWV if it is not provided by the patient's regular source of care. However, your Reference Committee notes that the language of the statute precludes this request and notes that this language impedes a provider from performing the AWV who is attempting to establish a relationship as the regular source of care and therefore does not accept this amendment. As a member of the Council on Medical Service stated, the report was drafted in response to the statute being written in such a way that it explicitly allows for various medical professionals to provide the AWV. The member noted that, while care is best coordinated and provided by the physician-led team, sometimes care is not provided in such a way and all parties must work to ensure continuity of care is preserved in these circumstances. Your Reference Committee concurs. Another speaker noted that the issues faced by physicians from the Medicare AWV mirror those from third party payer wellness visits and suggests a study of this issue. While your Reference Committee understands these concerns, it notes that the scope of this report is limited to the Medicare AWV. Additionally, your Reference Committee highlights that the Council on Medical Service is working on a report on retail health clinics for the 2017 Annual Meeting that may touch on such issues.

Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 5 - INCORPORATING
VALUE INTO PHARMACEUTICAL PRICING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 5 adopted.

Council on Medical Service Report 5 recommends that our AMA reaffirm Policies H-155.960, H-185.939, H-450.933, H-460.909 and D-390.961; support value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by outlined principles; support the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research; and support direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

There was generally supportive testimony on this report. A member of the Council on Medical Service introduced the report, noting that policymakers, insurers and other stakeholders are moving forward with efforts to integrate value into drug pricing. Testimony addressed the Council report's treatment of Medicare drug price negotiation. Your Reference Committee notes that the implementation of value-based pricing could have an impact on patient cost-sharing for prescription drugs in Medicare Part D. For example, pharmaceutical companies could be incentivized to list their drugs in accordance with value-based prices, which may include guaranteeing a drug's placement in the first tier of a Part D plan formulary and requiring no or nominal copayment or coinsurance if drugs have value-based prices. While acknowledging that Policy D-330.954 that supports eliminating the Medicare prohibition on drug price negotiation remains AMA policy, expanding the policy to grant the Secretary of HHS the authority to establish a formulary, develop a preferred tier in Medicare Part D, or set prices administratively in order to increase the likelihood of cost savings has the potential to adversely impact patient choice of Part D plans, as well

as patient access to the prescription drugs they need. Of note, none of the legislation introduced in Congress that would allow the Secretary of HHS to negotiate drug prices in Part D included any Republican sponsors or cosponsors, which is significant given the majority party of the House of Representatives and Senate in the 115th Congress which begins next year. Overall, your Reference Committee believes that the recommendations of this report fill a noteworthy gap in AMA policy with respect to value-based pricing – an approach that has the potential to impact the prices of drugs across the health care system. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

(4) RESOLUTION 802 - ELIMINATING FAIL FIRST POLICY IN ADDICTION TREATMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 802 be adopted.

RESOLVED, That our American Medical Association advocate for the elimination of the “fail first” policy implemented at times by some insurance companies and managed care organizations for addiction treatment. (New HOD Policy)

HOD ACTION: Resolution 802 adopted as amended.

Resolution 802 asks that our AMA advocate for the elimination of the “fail first” policy implemented by insurance companies for addiction treatment.

Testimony was supportive of Resolution 802. Speakers emphasized that patients with addiction and substance abuse disorders should not be subject to “fail first” policies that require them to fail, for example, an outpatient program before they are able to receive an appropriate level of care. Your Reference Committee agrees and recommends that Resolution 802 be adopted.

(5) RESOLUTION 807 - PHARMACY USE OF MEDICATION DISCONTINUATION MESSAGING FUNCTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 807 be adopted.

HOD ACTION: Resolution 807 adopted.

Resolution 807 asks that our AMA strongly encourage all software providers and those pharmaceutical dispensing organizations that create their own software to include the functionality to accept discontinuation message transmittals in their electronic prescribing software products; and strongly encourage all dispensing pharmacies accepting medication prescriptions electronically to activate the discontinuation message transmittal functionality in their electronic prescribing support software.

There was generally supportive testimony on this resolution. Your Reference Committee concurs with testimony on the need for additional policy specifically addressing the electronic cancellation of prescriptions, and as such recommends adoption of Resolution 807.

(6) COUNCIL ON MEDICAL SERVICE REPORT 2 - HEALTH CARE WHILE INCARCERATED

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

3. That our AMA support partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for ~~individuals~~ juveniles and adults in the correctional system. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

4. That our AMA encourage state Medicaid agencies to accept and process Medicaid applications from ~~individuals~~ juveniles and adults who are incarcerated. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 5 in Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

5. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated ~~individuals~~ juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Recommendation 6 in Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

6. That our AMA encourage states to suspend rather than terminate ~~an individual's~~ an individual's Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community. (New HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends Council on Medical Service Report 2 be amended by addition of a new Recommendation to read as follows:

That our AMA urge the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism. (New HOD Policy)

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 2 be amended by addition of a new Recommendation to read as follows:

That our AMA advocate for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women. (New HOD Policy)

RECOMMENDATION G:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

2. That our AMA advocate for adequate payment to health care providers, including primary care, ~~and~~ mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community. (New HOD Policy)

HOD ACTION: Council on Medical Service Report 2 adopted as amended.

Council on Medical Service Report 2 recommends that our AMA reaffirm Policy D-430.997; advocate for adequate payment to health care providers, including primary care and mental health professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community; support partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for individuals in the correctional system; encourage state Medicaid agencies to accept and process Medicaid applications from individuals who are incarcerated; encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated individuals who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid; encourage states to suspend rather than terminate an individual's Medicaid eligibility upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community; and rescind Policy D-430.994, which requested the study accomplished by this report.

Testimony on Council on Medical Service Report 2 was very supportive. A member of the Council on Medical Service introduced the report, noting that the incarcerated population has a higher rate of chronic disease and mental health conditions than the general population, and highlighting the report's recommendations, including several

related to state Medicaid agencies. Additional testimony spoke to the importance of having Medicaid coverage in place and health care services available at the time individuals transition out of incarceration and into their communities. One speaker suggested that the report recommendations specifically address both juveniles and adults, and your Reference Committee recommends amendments to Recommendations 3, 4, 5 and 6 to accomplish this suggestion.

An amendment was offered asking the AMA to urge the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before release from correctional facilities to help establish care in the community and reduce recidivism. A second amendment was offered requesting that the AMA advocate for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetric care for pregnant and postpartum women. There was substantial support for these amendments and your Reference Committee therefore recommends the addition of new recommendations. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report filed.

(7) COUNCIL ON MEDICAL SERVICE REPORT 4 - CONCURRENT HOSPICE AND CURATIVE CARE
RESOLUTION 812 - ENACT RULES AND PAYMENT MECHANISMS TO ENCOURAGE APPROPRIATE HOSPICE AND PALLIATIVE CARE USAGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 4 be amended by addition to read as follows:

4. That our AMA encourage physicians to be familiar with local hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended in lieu of Resolution 812 and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 4 adopted as amended in lieu of Resolution 812.

Council on Medical Service Report 4 recommends that our AMA reaffirm Policy H-85.966; support continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care; encourage CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services; and encourage physicians to be familiar with local hospice and palliative care resources and their benefit structures, and to refer seriously ill patients accordingly.

Resolution 812 asks that our AMA amend Policy H-85.955, Hospice Care, by addition to advocate that the Centers for Medicare and Medicaid Services enact rules and payment mechanisms to encourage appropriate hospice and palliative care utilization for eligible patients.

Testimony was very supportive of Council on Medical Service Report 4 and the intent of Resolution 812. A member of the Council on Medical Service introduced the report, highlighting recommendations calling for continued study

and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care, and also encouraging CMS to identify ways to optimize patient access to palliative care and to provide appropriate coverage and payment for these services. The sponsor of Resolution 812 testified in support of Council on Medical Service Report 4, suggesting that the report be adopted in lieu of Resolution 812. One speaker pointed out that several national medical specialty societies have developed clinical practice guidelines on hospice and palliative care. Your Reference Committee recommends amending Recommendation 4 to encourage physicians to be familiar with these guidelines. Accordingly, your Reference Committee recommends that Council on Medical Service Report 4 be adopted as amended in lieu of Resolution 812.

(8) COUNCIL ON MEDICAL SERVICE REPORT 6 - INTEGRATION OF MOBILE HEALTH APPLICATIONS AND DEVICES INTO PRACTICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

3. That our AMA support the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that:

- a) support the establishment or continuation of a valid patient-physician relationship;
- b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness;
- c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes;
- d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication;
- e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models;
- f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app;
- g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and
- h) ensure that the delivery of any services via the app be consistent with state scope of practice laws. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 6 be amended by addition of a new Recommendation to read as follows:

That our AMA assess the feasibility of state and federal legislation, as well as other innovative alternatives, in an effort to mitigate the physician's potential risk of liability from the use or recommendation of mHealth apps. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 6 adopted as amended.

Council on Medical Service Report 6 recommends that our AMA reaffirm Policies H-480.946 and H-100.980; support the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that follow outlined principles; support that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information; encourage the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used; encourage the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information; encourage physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws; encourage physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks; assess the potential liability risks to physicians for using, recommending, or prescribing mHealth apps, including risk under federal and state medical liability, privacy, and security laws; support further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy; and encourage national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

There was generally supportive testimony on this report. An amendment was offered to ensure that mHealth apps have the highest quality of evidence to support their use, and highlight the importance of evidence-based practice guidelines developed and produced by national medical specialty societies, and based on systematic reviews, being followed in mHealth app development and implementation. In addition, another amendment was offered to support the AMA assessing the feasibility of state and federal legislation, as well as other innovative alternatives, in an effort to mitigate the physician's potential risk of liability from the use or recommendation of mHealth apps. The Council on Medical Service accepted both amendments as friendly. Your Reference Committee believes that the recommendations of this report effectively address the obstacles that physicians and patients face in accepting and utilizing mHealth technologies. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

- (9) COUNCIL ON MEDICAL SERVICE REPORT 7 - HOSPITAL DISCHARGE COMMUNICATIONS
RESOLUTION 818 - IMPROVING COMMUNICATIONS AMONG HEALTH CARE CLINICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 7 be amended by addition of a new Recommendation to read as follows:

That our AMA support making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 7 be amended by addition of a new Recommendation to read as follows:

That our AMA develop model guidelines for physicians to improve communications to other physicians, hospital staff and patients, and promote these guidelines to payers, hospitals and patients. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted in lieu of Resolution 818 and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 7 adopted as amended in lieu of Resolution 818.

Council on Medical Service Report 7 recommends that our AMA reaffirm Policies D-478.995, H-160.942 and D-160.945; encourage the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization; encourage the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care; encourage hospital engagement of patients and their families/caregivers in the discharge process, using outlined guidelines; support implementation of medication reconciliation as part of the hospital discharge process, using suggested strategies to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged; encourage patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization; and encourage hospitals to review early readmissions and modify their discharge processes accordingly.

Resolution 818 asks that our AMA, in association with the AHA, assess the national impact of communication barriers and their negative impact on direct patient care in the hospital and after discharge between physician-physician in the hospital, in-hospital and after discharge care, and physician-patients and report to the HOD by the 2017 Interim Meeting; and research and develop guidelines that physicians can initiate in their communities to improve communication between physician-physician in the hospital, hospital and after discharge care, and physician-patients and report to the HOD by the 2017 Interim Meeting.

Testimony on Council on Medical Service Report 7 and Resolution 818 was generally supportive. A member of the Council on Medical Service testified that the report's recommendations are intended to complement the AMA's

extensive policy by honing in on several critical elements of the discharge process—including hospital engagement of patients and their families, and medication reconciliation—that can be adapted locally. Testimony noted that the report is a follow-up to Council on Medical Service Report 6-A-16, which focused on physician communications during patient hospitalizations. Frustration with lengthy discharge documents, which are often not well understood by patients, was expressed by speakers. Your Reference Committee believes that Recommendation 5, which encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, addresses this concern. Testimony also emphasized that improvements in interoperability of electronic health records and standardized electronic forms have the potential to enhance communications in the future.

An amendment was offered regarding patient access to discharge instructions via patient portals, as well as the ability of patients to delegate access to such portals to their designated caregivers. Your Reference Committee therefore recommends a new recommendation asking the AMA to support making hospital discharge instructions available to patients in both printed and electronic form, and specifically in online portals accessible to patients and their designated caregivers.

The sponsor of Resolution 818 expressed support for the report, and offered additional language requesting the AMA to develop guidelines for physicians to improve communications, and to promote such guidelines upon their completion. Your Reference Committee points out that the report references existing evidence-based programs including the SafeMed care transitions model, Project BOOST (Better Outcomes for Older Adults through Safe Transitions), and Project RED (Re-Engineered Discharge). Also, your Reference Committee recommends a new recommendation that asks the AMA to develop model guidelines for physicians to improve communications to other physicians, hospital staff and patients, and promote these guidelines to payers, hospitals and patients. Your Reference Committee recommends that Council on Medical Service Report 7 be adopted as amended in lieu of Resolution 818.

(10) RESOLUTION 804 - PARITY IN REPRODUCTIVE HEALTH INSURANCE COVERAGE FOR SAME-SEX COUPLES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 804 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support ~~parity in~~ insurance coverage for fertility treatments regardless of marital status or sexual orientation for same-sex couples, when insurance provides coverage for fertility treatments. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 804 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support local and state efforts to promote ~~parity in~~ reproductive health insurance coverage regardless of marital status or sexual orientation for same-sex couples when insurance provides coverage for fertility treatments. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 804 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 804 be changed to read as follows:

REPRODUCTIVE HEALTH INSURANCE COVERAGE

HOD ACTION: Resolution 804 adopted as amended with a change in title.

Resolution 804 asks that our AMA support parity in insurance coverage for fertility treatments for same-sex couples, when insurance provides coverage for fertility treatments; and support local and state efforts to promote parity in reproductive health insurance coverage for same-sex couples when insurance provides coverage for fertility treatments.

Testimony on Resolution 804 was unanimously supportive. Several speakers noted that AMA policy supports measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits as afforded to opposite-sex households (Policy H-65.973). Your Reference Committee believes this resolution is consistent with existing AMA work on non-discrimination and with existing policy on eliminating health care disparities. An amendment was offered to expand the resolution to include both sexual orientation and differing marital status. Your Reference Committee accepts this amendment. Additional testimony did not offer an amendment but noted that there is not infertility per se in some situations, specifically for same-sex couples, and that this policy should account for such situations. Your Reference Committee agrees and suggests striking mention of parity to address this issue. Accordingly, your Reference Committee recommends Resolution 804 be adopted as amended.

- (11) RESOLUTION 808 - A STUDY ON THE HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS) SURVEY AND HEALTHCARE DISPARITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 808 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the ~~potential healthcare disparities caused by~~ impact of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) ~~on in Medicare reimbursement payments to hospitals serving vulnerable populations and on potential health care disparities.~~ (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 808 be adopted as amended.

HOD ACTION: Resolution 808 adopted as amended.

Resolution 808 asks that our AMA study the potential healthcare disparities caused by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in Medicare reimbursement.

The majority of testimony on Resolution 808 was supportive. Your Reference Committee discussed two amendments that were offered. The first, which asked the AMA to study the disproportionate impact of pay-for-performance penalties, including those related to HCAHPS, substantially expanded the parameters of the original study requested in Resolution 808. A second amendment asked the AMA to urge the Centers for Medicare & Medicaid Services to amend HCAHPS without studying the survey's impact on health care disparities. Your Reference Committee recommends that Resolution 808 be adopted as amended, and requests that the future study

address the number of linguistic groups surveyed via HCAHPS and the need for adjustments that account for the socioeconomic status of patients and safety net disproportionate share hospitals.

(12) RESOLUTION 809 - ADDRESSING THE EXPLOITATION OF RESTRICTED DISTRIBUTION SYSTEMS BY PHARMACEUTICAL MANUFACTURERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 809 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek ~~Federal~~ Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 809 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities ~~the mandatory provision of samples~~ of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 809 be adopted as amended.

HOD ACTION: Resolution 809 adopted as amended.

Resolution 809 asks that our AMA advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Federal Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system; support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; and advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.

There was mixed testimony on Resolution 809. Speakers raised concerns with the language of the second resolve that would require mandatory provision of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays. There were also calls for referral. While your Reference Committee agrees that generic drug companies need improved access to appropriate quantities of out-of-patent drugs, your Reference Committee has offered an amendment to the second resolve to clarify that appropriate quantities should be accessible to generic drug manufacturers and available for purchase upon request. Your Reference Committee believes that Resolution 809 as amended would strengthen AMA policy addressing the utilization and impact of controlled distribution channels for pharmaceuticals, including those resulting from Risk Evaluation and Mitigation Strategies (REMS), as well as policy supporting an effective generic drug approval process. Accordingly, your Reference Committee recommends that Resolution 809 be adopted as amended.

(13) RESOLUTION 810 - MEDICAL NECESSITY OF BREAST RECONSTRUCTION AND REDUCTION SURGERIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 810.

HOD ACTION: Substitute resolution adopted in lieu of Resolution 810.

MEDICAL NECESSITY AND UTILIZATION REVIEW

RESOLVED, That our American Medical Association support efforts to ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery. (New HOD Policy)

Resolution 810 asks that our AMA support efforts to adapt medical necessity and insurance coverage decisions for assessment of preoperative symptomatology for macromastia without requirements for weight of volume resected during breast reduction surgery.

There was unanimous supportive testimony on Resolution 810. Substitute language and a title change were offered to encompass both medical necessity broadly and the specific breast reduction surgery requirements as issue. Additional testimony supported this substitute, and your Reference Committee agrees. Your Reference Committee notes it may be helpful to change “insurance coverage” to “utilization review” because the phrase “insurance coverage” may be overly inclusive as it would include all aspects of paying for a patient that are not necessarily based on clinical evidence, such as a patient not paying his or her premiums. Accordingly, your Reference Committee recommends adoption of alternate language in lieu of Resolution 810.

(14) RESOLUTION 814 - ADDRESSING DISCRIMINATORY HEALTH PLAN EXCLUSIONS OR PROBLEMATIC BENEFIT SUBSTITUTIONS FOR ESSENTIAL HEALTH BENEFITS UNDER THE AFFORDABLE CARE ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 814.

RESOLVED, That our American Medical Association work with state medical societies to ensure that no health carrier or its designee may adopt or implement a benefit design that discriminates on the basis of health status, race, color, national origin, disability, age, sex, gender identity, sexual orientation, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (Directive to Take Action); and be it further

RESOLVED, That our AMA work with state medical societies to see that appropriate action is taken by state regulators when discrimination may exist in benefit designs (Directive to Take Action); and be it further

RESOLVED, That our AMA support improvements to the essential health benefits benchmark plan selection process to ensure limits and exclusions do not impede access to health care and coverage (New HOD Policy); and be it further

RESOLVED, That our AMA encourage federal regulators to develop policy to prohibit essential health benefits substitutions that do not exist in a state's benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage (New HOD Policy); and be it further

RESOLVED, That our AMA encourage federal regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights. (New HOD Policy)

HOD ACTION: Alternate resolution adopted in lieu of Resolution 814.

Resolution 814 asks that our AMA work with state medical societies and their state regulators to facilitate the following: 1. Prohibit health plans from imposing arbitrary limits that are unreasonable or potentially discriminatory for coverage of the Essential Health Benefits (EHB). 2. Require any insurer, whose plans contain exclusions that are not in the state EHB benchmark plan, demonstrate that its benefits are substantially similar and actuarially equivalent to the benchmark, in compliance with federal regulations. 3. Define the state habilitative EHB definition that goes beyond the federal minimum definition. 4. Review current plans for discriminatory exclusions and require insurers to revise these plans if discriminatory exclusions present. 5. Review consumer complaints for incidents of discriminatory benefit and formulary design, cost-sharing, problematic EHB substitutions or exclusions. 6. Prohibit insurer benefit substitutions in the EHB.

Resolution 814 also asks that our AMA work with federal regulators to: 1. Improve the EHB benchmark plan selection process to ensure arbitrary limits and exclusions do not impede access to healthcare and coverage. 2. Develop policy to prohibit EHB substitutions that do not exist in a state's benchmark plan or selective use of exclusions or arbitrary limits to prevent high-cost claims or that encourage high-cost enrollees to drop coverage. 3. Review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights.

There was limited yet mixed testimony on Resolution 814. A member of the Council on Medical Service raised concerns that the language of the resolution was overly prescriptive. There were also calls for referral. However, your Reference Committee has offered substitute language to address the concerns highlighted in testimony, while supporting the intent of the original resolution. Your Reference Committee recommends adoption of alternate language in lieu of Resolution 814.

(15) RESOLUTION 815 - PRESERVATION OF PHYSICIAN-PATIENT RELATIONSHIPS AND PROMOTION OF CONTINUITY OF PATIENT CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 815 be amended by addition to read as follows:

RESOLVED, That our AMA support the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 815 be adopted as amended.

HOD ACTION: Resolution 815 adopted as amended.

Resolution 815 asks that our AMA support policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; support the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care; and support policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation.

Testimony on Resolution 815 was generally supportive. A member of the Council on Medical Service testified that protection of physician-patient relationships was the focus of Council on Medical Service Report 4-A-10, and that reaffirmation of existing policy may be appropriate. Several speakers supported an amendment to the second Resolve clause, which supports the ability of physicians to refer patients out-of-network when appropriate care is not available within a limited network of providers. Your Reference Committee concurs and recommends that Resolution 815 be adopted as amended.

- (16) RESOLUTION 805 - HEALTH INSURANCE COMPANIES SHOULD COLLECT DEDUCTIBLE FROM PATIENTS AFTER FULL PAYMENTS TO PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 805 be referred.

HOD ACTION: Resolution 805 referred for decision.

Resolution 805 asks that our AMA seek federal and state legislation that requires health insurers to reimburse physicians the full negotiated payment rate for services to enrollees in high deductible plans and that the health insurers collect any patient financial responsibility, including deductibles and co-insurance, directly from the patient.

There was generally supportive testimony on Resolution 805. Speakers stressed that patient collections have become a much more challenging issue with the advent of high-deductible health plans. However, your Reference Committee believes that Resolution 805 raises issues that warrant further study, due to the expected impact on physician practices, as well as the potential for unintended consequences. For example, some physicians may not want to cede patient collections to health plans as called for in Resolution 805. Physicians currently have the ability to offer discounts or payment plans to patients to facilitate good will – a business practice that would be impacted. Also, your Reference Committee believes that Resolution 805 has the potential to adversely affect physician payment, as well as the accounts receivable of physician practices. In addition, if Resolution 805 were implemented, health plans could potentially charge administrative fees or physician payment levels could be lowered resulting from a perceived decrease in the level of physician practice personnel needed, as well as overhead expenses. As such, your Reference Committee recommends that Resolution 805 be referred.

- (17) RESOLUTION 811 - OPPOSITION TO CMS MANDATING TREATMENT EXPECTATIONS AND PRACTICING MEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 811 be referred for decision.

HOD ACTION: Resolution 811 referred for decision.

Resolution 811 asks that our AMA oppose CMS creating mandatory standards of care that may potentially harm patients, disrupt the patient-physician relationship, and fail to recognize the importance of appropriate physician assessment, evidence-based medicine and goal-directed care of individual patients; communicate to hospitals that some CMS mandatory standards of care do not recognize appropriate physician treatment and may cause unnecessary harm to patients; and communicate to members, state and specialty societies, and the public the dangers of CMS' quality indicators potentially harming the patient-physician relationship.

There was generally supportive testimony on Resolution 811. Members from the Board of Trustees, Council on Medical Service and Council on Legislation noted that a resolution addressing the unintended consequences of core measures was referred at the 2016 Annual Meeting, so a report on the issues raised in Resolution 811 is already being developed for the 2017 Annual Meeting. Similar to Resolution 811, the referred resolution also responded to the core measure addressing severe sepsis and septic shock. Despite the study underway, speakers spoke to the urgency of the resolution, as the implementation of core measures has already begun, with the potential to interfere with how physicians practice medicine. A speaker also called for a moratorium of the implementation of core quality measures that have not been vetted by the physician community, including affected national medical specialty societies. There were calls to refer Resolution 811 for decision, as action may need to be taken by the AMA prior to the 2017 Annual Meeting. A member of the Board of Trustees also welcomed the referral of the resolution for decision. Your Reference Committee agrees that Resolution 811 should be referred for decision, to ensure that our AMA can develop a comprehensive and consistent response to core quality measures of the Centers for Medicare and Medicaid Services.

(18) RESOLUTION 813 - PHYSICIAN PAYMENT FOR INFORMATION TECHNOLOGY COSTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 813 be referred for decision.

HOD ACTION: Resolution 813 referred for decision.

Resolution 813 asks that our AMA assist in gathering and providing data that physicians can use to convince public and private payers that payment must cover the increasing information technology costs of physicians.

Testimony on Resolution 813 was overall supportive. A member of the Council on Medical Service testified that the problem does not appear to be lack of data and finds further data gathering unnecessary. Your Reference Committee agrees. The Council member stated that the AMA partnered with Dartmouth-Hitchcock in a 2015 joint research project to establish the amount of time that physicians spend on administrative tasks versus clinical care. Board of Trustees Report 11-A-15 outlined the methodology and research plan for this study, which involved direct observation of physicians in sixteen practices across four medical specialties and four geographic regions. The AMA and Dartmouth-Hitchcock authors prepared a manuscript describing the results of this study, which were published in the Annals of Internal Medicine in September 2016. The member noted that EHRs are not a one-size-fits all mechanism and that the request of this resolution may not be feasible and is not focused enough to achieve its intended objective. Your Reference Committee concurs and notes that this resolution may be overly simplistic since there are many cost facets of information technology including the cost of implementation, upgrades, maintenance, and time costs.

Additionally, your Reference Committee believes that adopting this resolution or the suggested amendment implicitly suggests that the AMA believes public and private payers must cover the information technology costs of physicians. Your Reference Committee believes this is potentially problematic and finds the issue to be more complex than the resolution or amendment convey. Accordingly, your Reference Committee recommends that Resolution 813 be referred for decision, with consideration of the proposed amendment.

(19) RESOLUTION 816 - SUPPORT FOR SEAMLESS PHYSICIAN CONTINUITY OF PATIENT CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 816 be referred for decision.

HOD ACTION: Resolution 816 referred for decision.

Resolution 816 asks that our AMA clearly support the concept of seamless continuity of care between hospital inpatient and outpatient care; and study whether there are instances of health insurers or HMO's precluding physicians via contracts from providing care to their patients in the in-patient setting for which the physician has clinical privileges.

Testimony on Resolution 816 was limited. Substitute language offered by the Senior Physicians Section asked the AMA to investigate the practice of risk management companies that require through Medicare Advantage subcontracts or by other means that physicians delegate care of their contracted patients to the management company's panel for approval of referrals, hospital and nursing home care, and put the physician at financial risk if they fail to follow such mandates.

A member of the Council on Medical Service testified that the substitute language offered by the Senior Physicians Section substantially changed the intent of Resolution 816 and suggested the item be referred for decision. Your Reference Committee agrees, and recommends that Resolution 816 be referred for decision.

(20) RESOLUTION 806 - PHARMACEUTICAL INDUSTRY DRUG PRICING IS A PUBLIC HEALTH EMERGENCY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 806 not be adopted.

HOD ACTION: Resolution 806 not adopted.

Resolution 806 asks that our AMA request that the Secretary of Health and Human Services declare pharmaceutical drug pricing a public health emergency under section 319 of the Public Health Service Act and that the Secretary take appropriate actions in response to the emergency, including investigations into the cause, treatment, or prevention of egregious pharmaceutical drug pricing.

There was mixed testimony on this resolution. Speakers, including members of the Council on Medical Service and Council on Legislation, stressed that prescription drug pricing falls outside the scope of a public health emergency as outlined in Section 319 of the Public Health Service Act (PHSA). Section 319 of the PHSA confers the Secretary of HHS with the authority to provide assistance to states and suspend legal requirements in the face of disease or disorder presenting a public health emergency including infectious disease outbreaks or bioterrorist attacks. Your Reference Committee concurs with speakers that stressed that misusing this provision of Section 319 will not further efforts to address prescription drug affordability. Furthermore, your Reference Committee agrees with testimony that the AMA is unlikely to make a defensible case that high drug prices constitute a disease or disorder. Your Reference Committee believes that our AMA should continue its advocacy in this arena based on its strong and comprehensive policy foundation that supports market-based strategies to achieve the affordability of prescription drugs, include advocating for prescription drug price and cost transparency; opposing "pay for delay" agreements; supporting shortening the exclusivity period for biologics; and supporting efforts to ensure fair and appropriate pricing of generic medications. As such, your Reference Committee recommends that Resolution 806 not be adopted.

(21) RESOLUTION 820 - RETROSPECTIVE PAYMENT DENIAL OF MEDICALLY APPROPRIATE STUDIES, PROCEDURES AND TESTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 820 not be adopted.

HOD ACTION: Resolution 820 referred with report back at the 2017 Annual Meeting.

Resolution 820 asks that our AMA advocate for legislation to require insurers' medical policies to reflect current evidence-based medically appropriate studies and treatments including those for rare and uncommon diseases; advocate for legislation to require insurers to implement a streamlined process for exceptions for rare or uncommon disease states; and advocate for legislation to prohibit insurers from using medical coding as the sole justification to deny medical services and diagnostic or therapeutic testing.

Your Reference Committee received no testimony on Resolution 820. Overall, your Reference Committee does not believe legislating medical policies is appropriate. Further, your Reference Committee does not know what exceptions are being requested in the second Resolve and believes the clause is ambiguous. Regarding the third Resolve, your Reference Committee believes it is a reaffirmation of current policy. Policy H-70.914 was recently adopted at the 2016 Annual Meeting and states that the AMA opposes limitations in coverage for medical services based solely on diagnostic code specificity. Further, Policy H-70.958 requests that CMS ensure its carriers fully understand and implement the distinction between coding to the "highest level of specificity" within a code category and coding for the condition(s) to the "highest degree of certainty." Your Reference Committee notes that, traditionally, when a diagnosis has not been established or when a code does not exist for a specific rare disease, general coding guidelines indicate that it is acceptable to use codes that describe signs and symptoms. Additionally, as written, this Resolve may undermine the current payment processing that allows for e-claims processing. As such, your Reference Committee recommends that Resolution 820 not be adopted.

(22) RESOLUTION 803 - REDUCING PERIOPERATIVE OPIOID CONSUMPTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-120.947 be reaffirmed in lieu of Resolution 803.

HOD ACTION: Policy D-120.947 reaffirmed in lieu of Resolution 803.

Resolution 803 asks that our AMA encourage hospitals to adopt practices for the management of perioperative pain that include services dedicated to acute pain management and the use of multimodal analgesia strategies aimed at minimizing opioid administration without compromising adequate pain control during the perioperative period.

Testimony on Resolution 803 was mixed, with substantial opposition to its adoption. A majority of speakers were concerned with encouraging hospitals to adopt practices for the management of perioperative pain that include services dedicated to acute pain management and the use of multimodal analgesia during the perioperative period. Some speakers viewed the resolution as overly prescriptive and as an unwanted mandate, emphasizing that decisions regarding pain management should be left to physicians and patients. Additionally, it was noted in testimony that pain management services may not be available in rural hospitals.

A member of the Council on Medical Service suggested reaffirming existing policy in lieu of Resolution 803. Additionally, the Council member pointed out that AMA advocacy efforts and the work of the AMA's Task Force to Reduce Opioid Abuse emphasize comprehensive pain management for all patients' pain whether it be perioperative, acute, emergency or chronic. Your Reference Committee agrees with this sentiment and recommends that Policy D-120.947 be reaffirmed in lieu of Resolution 803.

D-120.947 A More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief

1. Our AMA will consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics, including risk assessment and monitoring for substance use disorders, in the management of persistent pain. 2. Our AMA will urge the Centers for Disease Control and Prevention to take the lead in promoting a standard approach to documenting and assessing unintentional poisonings and deaths involving prescription opioids, including obtaining more complete information on other contributing factors in such individuals, in order to develop the most appropriate solutions to prevent these incidents. 3. Our AMA will work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications in long-term care facilities, in much the same way as is being done for hospice and palliative care. (BOT Rep. 3, I-13; Appended: Res. 522, A-16)

(23) RESOLUTION 817 - BRAND AND GENERIC DRUG COSTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-100.983; H-120.934; H-120.945; D-120.949; H-110.987; H-110.989; H-155.962 and H-110.988 be reaffirmed in lieu of Resolution 817.

HOD ACTION: Policies D-100.983; H-120.934; H-120.945; D-120.949; H-110.987; H-110.989; H-155.962 and H-110.988 reaffirmed in lieu of Resolution 817.

Resolution 817 asks that our AMA advocate for the following: 1. Investigate the purchasing of medications from outside the country with FDA guidance, on a temporary basis until availability in the U.S. improves; 2. Advocate to permit temporary compounding with FDA's guidance until medications are available; 3. Advocate to allow increased competition in the marketing of medications; 4. Advocate for participative pricing; 5. Advocate for accountability for outcomes; and 6. Advocate for increased regulation of the generic drug market.

There was limited, mixed testimony on Resolution 817. While testimony appreciated the intent of the resolution, speakers, including those from the Council on Legislation and Council on Medical Service, stressed that existing policy more appropriately responds to the issues outlined in the resolution. In addition, your Reference Committee notes that the language of Resolution 817 may not contain necessary safeguards, which could have unintended consequences. For example, supporting prescription drug reimportation without a requirement for track and trace, a requirement outlined in Policy D-100.983, could lead to significant safety concerns with the reimported prescription drugs, which may not be at the same quality or chemical makeup as those currently distributed in the US. There may also be unintended consequences associated with calling for blanket increased regulation of the generic drug market, and as such your Reference Committee believes that reaffirmation of Policy H-110.988 that outlines measures to help control the increasing costs of generic prescription drugs may be more appropriate. Your Reference Committee also notes that Council on Medical Service Report 5, Incorporating Value into Pharmaceutical Pricing, discusses outcomes-based pricing initiatives for prescription drugs, and presents recommendations to better incorporate value into pharmaceutical pricing. Overall, your Reference Committee believes that existing AMA policy appropriately responds to the issues raised in Resolution 817, and as such recommends that Policies D-100.983; H-120.934; H-120.945; D-120.949; H-110.987; H-110.989; H-155.962 and H-110.988 be reaffirmed in lieu of the resolution.

D-100.983 Prescription Drug Importation and Patient Safety

Our AMA will: (1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if: (a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations; (b) the drug distribution chain is "closed," and all drug products are subject to reliable, "electronic" track and trace technology; and (c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported; (2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured; (3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS) Task Force on Drug Importation and, as appropriate, revise its position

on whether or how patient safety can be assured under legalized drug importation; and (4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts. (BOT Rep. 3, I-04; Reaffirmation A-09)

H-120.934 Appropriate Use of Compounded Medications in Medical Offices

Our American Medical Association supports regulatory changes to improve access to (1) the compounding and repackaging of manufactured FDA-approved drugs and substances usually prepared in the office-based setting and (2) purchasing from compounding pharmacies of FDA-approved drugs, repackaged or compounded for the purpose of in-office use. (Res. 207, A-15 Reaffirmed: CMS Rep. 04, A-16 Reaffirmed: Res. 204, A-16)

H-120.945 Pharmacy Compounding

Our AMA: (1) recognizes that traditional compounding pharmacies must be subject to state board of pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications; (2) encourages all state boards of pharmacy to reference sterile compounding quality standards, including but not limited to those contained in United States Pharmacopeia Chapter 797, as the standard for sterile compounding in their state, and to satisfy other relevant standards that have been promulgated by the state in its laws and regulations governing pharmacy practice; (3) supports the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce be recognized as compounding manufacturers subject to FDA oversight and regulation; (4) supports the view that allowances must be made for the conduct of compounding practices that can realistically supply compounded products to meet anticipated clinical needs, including urgent and emergency care scenarios, in a safe manner; and (5) in the absence of new federal legislation affecting the oversight of compounding pharmacies, continues to encourage state boards of pharmacy and the National Association of Boards of Pharmacy to work with the United States Food and Drug Administration to identify and take appropriate enforcement action against entities that are illegally manufacturing medications under the guise of pharmacy compounding. (BOT Action in response to referred for decision Res. 521, A-06; Revised: CSAPH Rep. 9, A-13)

D-120.949 Ensuring the Safe and Appropriate Use of Compounded Medications

Our AMA will: (1) monitor ongoing federal and state evaluations and investigations of the practices of compounding pharmacies; (2) encourage the development of regulations that ensure safe compounding practices that meet patient and physician needs; and (3) report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices. (Sub. Res. 923, I-12; Reaffirmed: Res. 204, A-16)

H-110.987 Pharmaceutical Cost

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to

put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting. (CMS Rep. 2, I-15)

H-110.989 Pay for Delay Arrangements by Pharmaceutical Companies

Our AMA supports: (1) the Federal Trade Commission in its efforts to stop "pay for delay" arrangements by pharmaceutical companies and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as "pay for delay," illegal in the United States. (Res. 520, A-08; Appended: Res. 222, I-12; Reaffirmed: CMS 2, I-15)

H-155.962 Maximum Allowable Cost of Prescription Medications

Our AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services. (CMS Rep. 2, A-07; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed: CMS Res. 2, I-15)

H-110.988 Controlling the Skyrocketing Costs of Generic Prescription Drugs

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs. 2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients. 3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs. 4. Our AMA supports measures that increase price transparency for generic prescription drugs. (Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15)

REPORT OF REFERENCE COMMITTEE K

(1) BOARD OF TRUSTEES REPORT 9 - PRODUCT-SPECIFIC DIRECT-TO-CONSUMER ADVERTISING OF PRESCRIPTION DRUGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 9 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 9 adopted.

Board of Trustees Report 9 summarizes concerns and findings on the impact of DTCA and whether the AMA should maintain a comprehensive policy on what constitutes acceptable product-specific DTCA. Additionally, this report briefly considers whether establishing policy opposing industry tax credits for DTCA is advisable. The Board of Trustees recommends that the following statements be adopted in lieu of Second Resolve, Resolution 927-1-15 and Resolution 514-A-16:

- 1) That Policy H-105.988, “Direct-to-Consumer (DTC) Advertising (DTCA) of Prescription Drugs and Implantable Devices,” be amended by addition and deletion to read as follows:
It is the policy of our AMA:
 1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.
 2. That until such a ban is in place, 1. That our AMA considers acceptable only those our AMA opposes product-claim specific DTCA advertisements that does not satisfy the following guidelines:
 - (a) The advertisement should be indication-specific and enhance consumer education about both the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
 - (b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug’s or device’s approval for marketing.
 - (c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.
 - (d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as “Your physician may recommend other appropriate treatments,” is recommended.
 - (e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
 - (f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
 - (g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
 - (h) In general, product-claims specific DTCA advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA advertisements, a disclaimer should be prominently displayed.

- (i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
 - (j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
 - (k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.
- ~~2. That our AMA opposes product-specific DTC advertisements, regardless of medium, that do not follow the above AMA guidelines.~~
 3. That the FDA review and pre-approve all DTCA advertisements for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.
 4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.
 5. That DTCA advertisements for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.
 6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA advertisements.
 7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.
 8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
 9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claims-specific DTCA and with the Council on Ethical and Judicial Affairs (CEJA) Ethical Opinion E-5-0159.6.7 and to adhere to the ethical guidance provided in that Opinion.
 10. That the Congress should request the Agency for Healthcare Research and Quality (AHRQ) or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
 11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.
 12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.
 13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA). (Modify Current HOD Policy)

- 2) That Policy H-105.986, “Ban Direct-to-Consumer Advertisements of Prescription Drugs and Implantable Devices,” be rescinded as it is now incorporated into amended Policy H-105.988.

Limited but supportive testimony was offered on Board of Trustees Report 9. AMA policy supports a ban on product specific direct-to-consumer advertising (DTCA), but given the current First Amendment protections for this practice, a need exists to maintain AMA policy on what constitutes an acceptable DTCA. DTCA that promotes public health, such as those for CDC recommended immunizations, should be considered *a priori* as acceptable.

- (2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 - GENOME EDITING AND ITS POTENTIAL CLINICAL USE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 3 adopted.

Council on Science and Public Health Report 3 was initiated to inform physicians and the House of Delegates about the recent remarkable advances in genome editing and its potential clinical applications in gene therapy, as well as concerns about it and proposals to ensure its responsible use. The Council on Science and Public Health recommends that our AMA 1. encourage continued research into the therapeutic use of genome editing; and 2. encourage continued analysis of potential uses of germline editing and the development of international principles to guide appropriate use.

Unanimously supportive testimony was received on CSAPH Report 3. The Council was thanked for informing the House on the transformative technology of genome editing. Testimony expressed concern for the potential ethical abuses that may arise from genome editing technology, such as choosing “desirable” physical traits. Your Reference Committee agrees with this concern, but points out that the National Academy of Sciences, Engineering and Medicine will be releasing a report late in 2016 that explores ethical concerns and ways to address such concerns, and that the Council’s Recommendation 2 urges the development of principles grounded in science and ethics to determine the permissible uses of germline genome editing. Your Reference Committee therefore recommends that Council on Science and Public Health Report 3 be adopted.

- (3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 - HORMONE THERAPIES: OFF-LABEL USES AND UNAPPROVED FORMULATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 4 adopted as amended by the addition of a fourth Recommendation.

4. That our AMA establish a position that the use of human chorionic gonadotropin (HCG) for weight loss is inappropriate.

Council on Science and Public Health Report 4 is intended to inform physicians about the use of off-label and unapproved uses of hormones, especially compounded hormone therapies. The Council on Science and Public Health recommends the following recommendations be adopted in lieu of Res 512-A-15:

1. That Policy D-120.969 be amended by addition and deletion to read as follows:
D-120.969 ~~FDA Oversight of Bioidentical~~ Compounded Hormone (BH) Therapy Preparations

Our AMA ~~will~~: (1) recognizes the term “bioidentical hormone” as a marketing term not grounded in science; use of the term “compounded hormone therapy” is preferred; ~~(+2) will urge that renewed attention be devoted to the of the Food and Drug Administration (FDA) to conduct surveys for purity and potency dosage accuracy of all-compounded hormone therapy “bioidentical hormone” formulations; (23) will urge continued attention to the FDA to require mandatory reporting by drug manufacturers, including compounding pharmacies, of adverse events related to the use of compounded hormone therapies “bioidentical hormones”;~~ (3) urge the FDA to create a registry of adverse events related to the use of compounded “bioidentical hormone” preparations; (4) recommends that physicians and other prescribers fully inform patients of the potential side effects and risks of the use of compounded hormone replacement therapy; and (5) will request that when drug ingredients with black box warnings are used in compounded products, patients should be informed about the FDA require the inclusion of uniform patient information, such as warnings and precautions associated with the use of such drug ingredients, in packaging of compounded “bioidentical hormone” products; and ~~(5) urge the FDA to prohibit the use of the term “bioidentical hormones” unless the preparation has been approved by the FDA.~~

2. Our AMA supports that patients be informed that compounded products are not FDA-approved.
3. That our AMA urge the United States Pharmacopeia to re-examine the validity of the current estriol monograph.

Considerable support was offered for Council on Science and Public Health Report 4. Most of the testimony was on the wisdom of adding a recommendation that would link the use of hormone replacement therapy with a specific deficiency diagnosis, confirmed with laboratory values. Speakers provided evidence based examples where this type of approach was not necessary or not clinically relevant. A request also was made for the AMA to explicitly establish a position that the use of human chorionic gonadotropin for weight loss is inappropriate. This issue was evaluated in the report, but your Reference Committee believes that such a statement in the policy compendium is unnecessary and urges adoption of the report.

(4) RESOLUTION 903 – PREVENTION OF NEWBORN FALLS IN HOSPITALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 903 be adopted.

HOD ACTION: Resolution 903 adopted.

Resolution 903 asks that our AMA support implementation of newborn fall prevention plans and post-fall procedures through clinically proven, high-quality, and cost-effective approaches.

Your Reference Committee heard supportive testimony for this item. Newborn falls can result in injury or even death of the newborn and severe emotional distress to the parents and caregiver(s), but falls are preventable. Institutions have taken measures to reduce falls such as awareness and education efforts for expectant parents and hospital/birthing center staff. Some testimony supported the term “drops” since many instances of falls occur when parents or caregivers accidentally drop the infant. However, the term “falls” is the standard terminology in research literature, e.g., infants falling from furniture when they are not being carried or held. The American Academy of Pediatrics testified that its recently updated guidelines on safe infant sleep include several recommendations that support falls prevention, and requested that those recommendations be explicitly supported in the resolution. However, your Reference Committee believes that the broad nature of the original language is inclusive of all clinically-proven approaches. Therefore, your Reference Committee recommends that Resolution 903 be adopted.

(5) RESOLUTION 926 – ESTABLISHING AND ACHIEVING NATIONAL GOALS TO ELIMINATE LEAD POISONING AND PREVENT LEAD EXPOSURES TO CHILDREN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 926 be adopted.

HOD ACTION: Resolution 926 adopted.

Resolution 926 asks that our American Medical Association 1. call on the United States government to establish national goals to: a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level > 1 µg/dL (10 ppb); and 2. Call on the United States government in all its agencies to pursue the following strategies to achieve this goal: a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment, b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed, c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services, d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions, e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead, and f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 µg/dL (10 ppb).

Your Reference Committee heard testimony unanimously supportive of Resolution 926. National goals and standards for addressing elevated blood lead levels in children are included as a part of Healthy People 2020 and have been established based on data from the National Health and Nutrition Examination Survey. Establishing new national goals and pursuing the outlined strategies to achieve these goals should prevent future public health emergencies, like the one experienced in Flint, Michigan. Therefore, your Reference Committee recommends adoption.

(6) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - URINE DRUG TESTING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that part 2 of Recommendation 1 in Council on Science and Public Health Report 1 be amended by addition on page 13, line 13, to read as follows:

1. That Policy H-95.985, “Drug Screening and Mandatory Drug Testing,” be amended by addition and deletion as follows:

2. Results from such drug testing programs can yield accurate evidence of prior exposure to drugs. Drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, abuse of or physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use; nor does it provide valid or reliable information about harm or potential risk of harm to children or, by itself,

provide indication or proof of child abuse, or neglect or proof of inadequate parenting.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that part 4 of Recommendation 1 in Council on Science and Public Health Report 1 be amended by addition on page 13, line 26 to read as follows:

1. That Policy H-95.985, “Drug Screening and Mandatory Drug Testing,” be amended by addition and deletion as follows:

4. Since physicians often are called upon to interpret results, they should be familiar with the ~~disposition characteristics pharmacokinetic properties~~ of the drugs to be tested ~~before interpreting any results, and the use to which the results will be put.~~ If interpretation of any given result is outside of the expertise of the physician, assistance from appropriate experts, such as a certified Medical Review Officer, should be pursued. (Modify Current HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 1 adopted as amended.

Council on Science and Public Health Report 1 was initiated to help promulgate urine drug testing (UDT) as a medical management tool that can be used to better serve patient populations. This report recommends:

1) That Policy H-95.985 be amended by addition and deletion as follows:

~~Drug Screening and Mandatory Drug~~ Testing

The AMA believes that physicians should be familiar with the strengths and limitations of drug ~~screening testing~~ techniques and programs:

2. Due to the limited specificity of the inexpensive and widely available ~~non-instrumented devices such as point-of-care drug testing devices screening techniques, forensically~~ acceptable ~~clinical drug~~ testing programs ~~must should~~ include ~~the ability to access~~ highly specific, ~~analytically acceptable technically~~ ~~more complicated and more expensive~~ confirmation techniques, which ~~unequivocally definitively~~ establishes the identities and quantities of drugs, ~~in order to further analyze results from presumptive testing methodologies.~~ Physicians should consider the value of data from non-confirmed preliminary test results, and should not make major clinical decisions without using confirmatory methods to provide assurance about the accuracy of the clinical data.
3. Results from ~~such~~ drug testing programs can yield accurate evidence of prior exposure to drugs. Drug testing does not provide any information about pattern of use of drugs, ~~dose of drugs taken, abuse of or physical~~ dependence on drugs, ~~the presence or absence of a substance use disorder,~~ or about mental or physical impairments that may result from drug use.
4. ~~Before implementing a drug testing program,~~ Physicians ~~need to be aware of~~ ~~should:~~ (a) understand the objectives ~~of a drug testing program in which they participate~~ and questions they want to answer with testing; (b) understand the advantages and limitations of the testing technology; (c) be aware of and educated about the drugs chosen for inclusion in the drug test; and (d) ensure that the cost of testing aligns with the expected benefits for their patients. ~~and they~~ Physicians also should be satisfied that the selection of ~~drugs (analytes) and subjects to be tested as well as~~ ~~and~~ the screening and ~~confirming~~ confirmatory techniques that are used meet the ~~stated~~ objectives.
5. Since physicians often are called upon to interpret results, they should be familiar with the ~~disposition characteristics pharmacokinetic properties~~ of the drugs to be tested ~~before interpreting any results, and the use to which the results will be put.~~ If interpretation of any given result is outside of the expertise

- of the physician, assistance from appropriate experts should be pursued.
- 2) That our AMA, in conjunction with the AMA Opioid Task Force, develop practical guidance and educational materials to assist physicians with implementing urine drug testing as part of a risk mitigation strategy when opioid analgesics are prescribed for chronic use.

Strong support was offered for Council on Science and Public Health Report 1 as useful guidance for practicing physicians. One speaker noted that the Council may wish, in the future, to address drug testing in patients admitted to the hospital. The Council recommended adding a notation regarding medical review officers in Recommendation 1 and testimony also supported adding information on the inappropriate use of drug testing results to make judgements about pregnant women or parenting. Your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted as amended.

(7) RESOLUTION 902 – REMOVING RESTRICTIONS ON FEDERAL PUBLIC HEALTH CRISIS RESEARCH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 902 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA oppose efforts to restrict funding or suppress the findings of biomedical and public health research for ~~the purpose of influencing political discourse~~ purposes. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 902 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 902 be changed, to read as follows:

OPPOSE RESTRICTIONS ON PUBLIC HEALTH RESEARCH

HOD ACTION: Resolution 902 adopted as amended with a change in title.

Resolution 902 asks that our AMA recognize the importance of timely research and open discourse in combatting public health crises and oppose efforts to restrict funding or suppress the findings of biomedical and public health research for the purpose of influencing political discourse.

Your Reference Committee heard testimony largely supportive of the intent of Resolution 902. While the AMA has extensive policy supporting public health research and condemning inappropriate political influence on funding decisions, this resolution specifically focuses on restricting public health funding. Your Reference Committee agreed with testimony that a minor amendment was needed to clarify the intent of the second Resolve statement. The title was also changed to broaden the focus to all public health research rather than just federal public health crisis research. Therefore, your Reference Committee recommends that Resolution 902 be adopted as amended.

(8) RESOLUTION 904 – IMPROVING MENTAL HEALTH AT COLLEGES AND UNIVERSITIES FOR UNDERGRADUATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 904 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association support strategies that emphasize de-stigmatization and enable timely and affordable access to accessibility and de-stigmatization as strategies in mental health services for undergraduate and graduate students ~~measures implemented by colleges and universities~~, in order to improve the provision of care and increase its use by those in need (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 904 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA support colleges and universities in ~~publicizing~~ emphasizing to undergraduate and graduate students and parents the importance, ~~of mental health resources, with an emphasis on the~~ availability, and efficacy of ~~such~~ mental health resources (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 904 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA support collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is ~~be~~ able to access care in a timely and affordable manner. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 904 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Resolution 904 be changed, to read as follows:

IMPROVING MENTAL HEALTH SERVICES FOR UNDERGRADUATE AND GRADUATE STUDENTS

HOD ACTION: Resolution 904 adopted as amended with a change in title.

Resolution 904 asks that our AMA support 1. accessibility and de-stigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need; 2. colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources; and 3. collaborations of university mental health

specialists and local health centers in order to provide a larger pool of resources, such that any student be able to access care in a timely and affordable manner.

Your Reference Committee heard unanimously supportive testimony about the importance of accessible mental health services on college and university campuses. An increasing number of students are experiencing disorders such as depression, anxiety, suicidal ideation, alcohol misuse, eating disorders, and self-injury, and mental health centers on campuses have struggled to provide care to all those in need. Amendments were suggested to ensure that parents are aware of the importance of mental health services and their availability for their sons and daughters who are students, and for mechanisms to collaborate with local mental health providers to ensure timely access. Your Reference Committee agrees with the importance of providing mental health services for college and university students, including graduate students, and believes that the recommendation should be adopted with the addition of the suggested amendments and clarifying language.

(9) RESOLUTION 905 – CHRONIC TRAUMATIC ENCEPHALOPATHY (CTE) AWARENESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 905 be amended by addition and deletion, to read as follows:

~~RESOLVED, That our American Medical Association amend part one of H-470.954 by addition and deletion to read as follows:
Reduction of Sports Related Injury and Concussion H-470.954:
1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences; and (c) promote education for physicians and the public on the detection, treatment and prognosis of chronic traumatic encephalopathy (CTE). (Modify Current HOD Policy); and be it further~~

RESOLVED, That our AMA support work with interested agencies and organizations to advocate for further research into the ~~detection~~, causes, and ~~prevention and treatments for~~ of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE). (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 905 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Policy H-470.954 be reaffirmed.

HOD ACTION: Resolution 905 adopted as amended and Policy H-470.954 reaffirmed.

Resolution 905 asks that our AMA:

- 1) Amend part one of Policy H-470.954, “Reduction of Sports-Related Injury and Concussion,” by addition and deletion to read as follows:
 1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; ~~and~~ (b) promote

- awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences; and (c) promote education for physicians and the public on the detection, treatment and prognosis of chronic traumatic encephalopathy (CTE); and
- 2) Work with interested agencies and organizations to advocate for further research into the causes of and treatments for chronic traumatic encephalopathy (CTE).

Your Reference Committee heard testimony in support of maintaining existing policy. Therefore, your Reference Committee recommends reaffirming Policy H-470.954. While there was broad support for increased awareness and research into the causes of chronic traumatic encephalopathy (CTE) and measures to prevent it, others noted that CTE can only be diagnosed post-mortem. Several delegations opposed the amendment called for in Resolve 1 since antemortem detection of CTE is not possible at this time, nor is treatment. Testimony pointed out that radiographic detection methods are improving, and anatomic changes due subconcussive injury may be detectable. Many speakers supported the research called for in Resolve 2. Your Reference Committee concurs that there is value in supporting research on CTE, as well as on the continuum of subconcussive head impacts that may lead to more permanent injury and impairment. It therefore recommends adoption of the second resolve with these amendments.

Policy recommended for reaffirmation:

H-470.954 Reduction of Sports-Related Injury and Concussion

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences. 2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations. 3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries. 4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients. CSAPH Rep. 3, A-15

(10) RESOLUTION 908 – FAITH AND MENTAL HEALTH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following Resolution be adopted in lieu of Resolution 908, to read as follows:

FAITH AND MENTAL HEALTH

RESOLVED, That our American Medical Association support mental health and faith community partnerships that foster improved education and understanding ~~for faith leaders~~ regarding culturally competent, medically accepted, and scientifically proven methods of care for psychiatric and substance use disorders (Directive to Take Action); and be it further

RESOLVED, That our AMA support better understanding on the part of mental health providers of the role of faith in mental health and addiction recovery for some individuals, (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts of mental health providers to create respectful, collaborative relationships with local religious leaders to improve access to scientifically sound mental health services. (Directive to Take Action)

HOD ACTION: Alternate resolution adopted as amended in lieu of Resolution 908.

Resolution 908 asks that our AMA 1. advocate and support mental health and faith community partnerships that will provide a platform for faith leaders to get educated about psychiatric and substance abuse disorders and mental health providers understand the role of faith in recovery; and 2. study and support a partnership to foster respectful, collaborative relationships between psychiatrists, other mental health providers and the faith-based community to improve quality care for individuals and families with mental health and substance abuse problems.

Your Reference Committee heard positive testimony for this resolution. The important role of faith in recovery of some patients was underscored, as well as the need for improvement in access to mental health services. The APA partnered to develop the Mental Health and Faith Community Partnership, a collaboration between psychiatrists and clergy aimed at fostering a dialogue between the two fields, reducing stigma, and accounting for medical and spiritual dimensions as people seek care. The GLMA suggested substitute language that maintained the spirit of the resolution but emphasized medically accepted and scientifically proven mental health services. The resolution sponsors, the IMG Section, concurred with these changes. The ASAM proposed that addiction medicine be called out as a specific mental health service, but your Reference Committee believes it is appropriate to maintain “mental health services” as a more general statement so that it refers to all mental health disorders and services. Your Reference Committee recommends adoption of the substitute language offered by GLMA and supported by the IMG Section.

(11) RESOLUTION 910 – DISPARITIES IN PUBLIC EDUCATION AS A CRISIS IN PUBLIC HEALTH AND CIVIL RIGHTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 910 be amended by addition to read as follows:

RESOLVED That our AMA issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 910 be amended by addition of a third Resolve to read as follows:

RESOLVED, that our AMA acknowledge the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 910 be adopted as amended.

HOD ACTION: Resolution 910 adopted as amended.

Resolution 910 asks that our AMA consider continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; and issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education as one of the great unmet health and civil rights challenges of the 21st century.

Your Reference Committee heard testimony unanimously in support of this Resolution. Research has consistently linked educational attainment with health outcomes. Testimony from the AAP highlighted the importance of the role of early childhood education in brain development and an amendment was offered to address this issue. Your Reference Committee agrees that early childhood education is important and therefore, recommends adoption as amended.

(12) RESOLUTION 911 – IMPORTANCE OF ORAL HEALTH IN MEDICAL PRACTICE**RECOMMENDATION A:**

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 911 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association recognize the importance of a.) managing oral health, and b.) access to dental care as a part of optimal overall patient care (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 911 be amended by deletion, to read as follows:

RESOLVED, That our ~~AMA support efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health~~ (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 911 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~encourage closer~~ explore opportunities for collaboration of physicians with the American Dental Association on a dental providers to provide comprehensive strategy for improving oral health medical care and education for clinicians. (New HOD Policy); ~~and be it further~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 911 be amended by deletion, to read as follows:

RESOLVED, That the ~~AMA support efforts to increase access to oral health services.~~ (New HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 911 be adopted as amended.

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that the title of Resolution 911 be changed to read as follows:

IMPORTANCE OF ORAL HEALTH IN PATIENT CARE

HOD ACTION: Resolution 911 adopted as amended with a change in title.

Resolution 911 asks that our AMA 1. recognize the importance of managing oral health as a part of overall patient care; 2. support efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health; 3. encourage closer collaboration of physicians with dental providers to provide comprehensive medical care; and 4. support efforts to increase access to oral health services.

Testimony highlighted existing evidence of a link between poor oral hygiene, development of periodontal disease, and its relationship with other systemic diseases. Overall patient care, health, and dental health outcomes could be improved by more attention to oral health by physicians and better collaboration between physicians and dentists. The importance of care that “reconnects the mouth to the rest of the body” was underscored. A number of amendments were suggested on topics such as training, effects on reproductive health, and creative mechanisms that practices can implement to promote oral and dental health care. Your Reference Committee believes that in lieu of the many amendments, simplification of the language, emphasizing importance of oral health and access to dental care, and exploring opportunities for collaboration with the American Dental Association to improve oral health care, is called for, and recommends adoption with these amendments.

(13) RESOLUTION 912 – NEUROPATHIC PAIN RECOGNIZED AS A DISEASE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 912 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association recognize neuropathic pain as a distinct pain condition ~~disease state~~ with multiple pathophysiological aspects requiring a range of interventions different from other pain conditions ~~to advance neuropathic pain treatment and prevention~~; and be it further (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 912 be amended by the addition of a second Resolve, to read as follows:

RESOLVED, That our AMA support efforts to educate patients and physicians and other healthcare providers on the appropriate prevention and treatment of neuropathic pain.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 912 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 912 be changed, to read as follows:

NEUROPATHIC PAIN

HOD ACTION: Resolution 912 referred.

Resolution 912 asks that our AMA recognize neuropathic pain as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance neuropathic pain treatment and prevention.

Conflicting opinions were expressed about the validity and wisdom of categorizing neuropathic pain as a disease, although there was general agreement that neuropathic pain must be treated differently than other pain states (e.g., nociceptive, inflammatory). Proponents believe that declaring neuropathic pain as a disease would foster better treatment and reduce the overuse of opioids for the treatment of neuropathic pain symptoms. Opponents strongly expressed the view that any distinctions are “symptom” and not disease-related. One person noted that if neuropathic pain is designated as a disease, it may be used for disability claims. Significant support was offered for an amendment that emphasized neuropathic pain as a distinct pain “condition” in need of specific interventions. The Council on Science and Public Health previously examined this issue in 2010, but did not expressly recommend that neuropathic pain (or maldynia) be considered a disease. Your Reference Committee agrees that it is not appropriate at this time to declare neuropathic pain as a disease.

(14) RESOLUTION 913 – IMPROVING GENETIC TESTING AND COUNSELING SERVICES IN HOSPITALS AND HEALTHCARE SYSTEMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 913 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association support appropriate efforts to assess the usage utilization of genetic testing, and need for access to pre- and post-test counseling for patients undergoing genetic testing services, and physician preparedness in counseling patients or referring them to board-certified qualified genetics specialists (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 913 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA support the development and dissemination of encourage efforts to create and disseminate guidelines for best practice standards concerning pre- and post-test genetic counseling for genetic test results (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 913 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce levels shortage, physician preparedness in the provision of genetic testing and

counseling services, and impact of genetic testing results and counseling on patient care and outcomes satisfaction. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 913 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Resolution 913 be changed, to read as follows:

IMPROVING GENETIC TESTING AND COUNSELING SERVICES

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Policy H-460.902 be reaffirmed.

HOD ACTION: Resolution 913 adopted as amended with a change in title and Policy H-460.902 reaffirmed.

Resolution 913 asks that our AMA 1. support efforts to assess the usage of genetic testing and need for counseling services, physician preparedness in counseling patients or referring them to board-certified genetics specialists; 2. encourage efforts to create and disseminate guidelines for best practice standards concerning counseling for genetic test results; and 3. support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction.

Your Reference Committee heard mostly supportive testimony for this resolution. Studies have previously noted that a gap exists in genetic testing knowledge and counseling skills among physicians. Testimony pointed out that genetic testing has become progressively more complex. Concern was raised about the recent practices of some insurance companies to restrict genetic test ordering to only patients that have received pre-test counseling from a medical geneticist or genetic counselor. Your Reference Committee believes that the AMA should support efforts to improve appropriate genetic testing and access to counseling services, and recommends amendments to the resolution to make it more direct and clear. Specifically, instead of calling for more assessments of genetic test usage and counseling, your Reference Committee recommends amendments to Resolve 1 that directly support appropriate testing and access to counseling services. It also recommends replacing “board-certified” with “qualified” because testimony underscored that many providers, such as oncologists, are proficient in providing counseling services even though they may not be board-certified in medical genetics or genetic counseling. Your Reference Committee also recommends amendments to Resolves 2 and 3 that support best practice guidelines, and research into issues in medical genetics. In Resolve 3, it offers an amendment supporting research into the impact of testing and counseling on patient care and outcomes, rather than patient satisfaction, since this will contribute to efforts to define the clinical situations in which genetic testing is appropriate. It also recommends a title change to include genetic testing and counseling improvements in all settings. Finally, your Reference Committee recommends reaffirmation of Policy H-460.902, which opposes the practice of insurance companies restricting genetic test ordering to only certain specialists.

Policy recommended for reaffirmation:

H-460.902 Opposition to Genetic Testing Restrictions Based on Specialty

1. Our AMA opposes limiting the ordering of genetic testing based solely on physician specialty or other non-medical care based criteria. 2. Our AMA opposes public and private payers imposing a standard of practice with requirements for utilization of non-affiliated medical specialists or non-physicians prior to ordering genetic testing. 3. Our AMA, working with other interested specialty and component societies, will communicate our opposition to non-medical restrictions to genetic testing to relevant health insurers. 4. Our AMA will continue

to support the importance of pre- and post-testing counseling when a patient is considered to be at risk for a hereditary susceptibility for cancer and other diseases by a qualified health professional so that patients have the benefit of informed decision-making regarding genetic testing. Res. 115, A-14

(15) RESOLUTION 914 – NEEDLE / SYRINGE DISPOSAL

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-95.958 be amended, to read as follows:

H-95.958 Syringe and Needle Exchange Programs

Our AMA: (1) encourages all communities, ~~especially those with a drug injection use problem~~, to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes. (Res. 231, I-94; Reaffirmed Ref. Cmt. D, I-96; Modified by CSA Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: Res. 203, A-13)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Policy H-95.958 be adopted in lieu of Resolution 914.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Policy H-95.942 be reaffirmed.

HOD ACTION: Policy H-95.958 adopted as amended in lieu of Resolution 914 and Policy H-95.942 reaffirmed.

Resolution 914 asks that our AMA 1. support the requirement that medical facility needle/syringe disposal devices be as theft-proof and tamper-proof as possible; this requirement could be established by rule or statute; 2 support the requirement that stored used needles/syringes be properly secured so as to discourage theft; 3. support the requirement that theft and tamper-proof containers be placed in public restrooms for the purpose of needle/syringe disposal; an ideal device would crush the syringe as part of the disposal process; and 4. encourage those communities with a significant IV drug abuse population to establish a needle exchange program, since this helps eliminate the demand for used needles/syringes.

Considerable testimony was provided in support of Resolution 914, and the evidence base demonstrating the effectiveness of needle exchange programs in reducing the spread of blood borne infectious diseases among injection drug users. Concerns were expressed about the type of mandates included in this resolution and the cost of implementation given that many needle disposal devices and programs currently exist. Ultimately, the types of disease clusters or local epidemics that prompted this resolution are fostered by a combination of poverty, addiction, lack of public transportation, lack of access to physicians and treatment facilities for substance use disorders, as well as a lack of HIV-related funding, services, and awareness. Stigma that discourages testing and treatment also may contribute. Therefore, your Reference Committee recommends that attention be focused on the development of effective needle exchange programs with continued attention to community needle disposal initiatives.

Policy recommended for reaffirmation:

H-95.942 Safe Disposal of Used Syringes, Needles and Other Sharps in the Community

1. Our AMA recognizes that used sharps in the community pose a public health hazard in diverse ways to workers and to the public. 2. The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal. 3. Our AMA continues to support the mission of the Coalition for Safe Community Needle Disposal.

(16) RESOLUTION 915 – WOMEN AND ALZHEIMER'S DISEASE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 915 be amended by addition and deletion, to read as follows:

~~RESOLVED, That our American Medical Association support increased participate in efforts to raise awareness of the noted sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias (Directive to Take Action); and be it further~~

RESOLVED, That our American Medical Association support increased

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 915 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA make readily available to physicians the relevant guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 915 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA encourage physicians to consider performing regular cognitive testing as a part of wellness visit protocols for older adults, especially patients with increased risk of developing Alzheimer's disease and other forms of dementia, including, but not limited to, female sex, genetics, and cardiovascular co-morbidities (New HOD Policy); and be it further~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 915 be amended by addition and deletion, to read as follows:

~~RESOLVED, That our AMA encourage increased enrollment in clinical trials of with all appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias. (New HOD Policy)~~

RESOLVED, That our AMA encourage increased enrollment in clinical trials of

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 915 be adopted as amended.

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Policy H-25.991 be reaffirmed.

HOD ACTION: Resolution 915 adopted as amended and Policy H-25.991 reaffirmed.

Resolution 915 asks that our AMA 1. participate in efforts to raise awareness of the noted sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; 2. make readily available to physicians the relevant guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias; 3. encourage physicians to consider performing regular cognitive testing as a part of wellness visit protocols for older adults, especially patients with increased risk of developing Alzheimer's disease and other forms of dementia, including, but not limited to, female sex, genetics, and cardiovascular co-morbidities; and 4. encourage increased enrollment in clinical trials with all appropriate patients with Alzheimer's and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's and related dementia.

Your Reference Committee heard supportive testimony for this resolution. The Women Physicians Section testified that more women than men develop Alzheimer's Disease (AD), that women are more likely than men to progress to cognitive impairment, and have significantly greater deterioration of cognition than men. The need for greater awareness of this sex difference, as well as research into better treatments, was underscored. Your Reference Committee notes that AMA Policy H-25.991 already encourages physicians to make use of clinical guidelines for the diagnosis and treatment of AD and other dementias, addressing Resolve 2. Additionally, the Medicare Annual Wellness Visit includes assessment for cognitive function, and several organizations have guidelines for screening, addressing Resolve 3. Therefore, your Reference Committee recommends that Resolution 915 be adopted with amendments that clarify language in Resolves 1 and 4, and that remove Resolves 2 and 3. It also recommends reaffirmation of Policy H-25.991 to re-emphasize the appropriate use of guidelines for AD diagnosis and treatment.

Policy recommended for reaffirmation:

H-25.991 Alzheimer's Disease

The AMA encourages: (1) physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias; (2) physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services; (3) studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders; and (4) studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders. CSA Rep. 6, I-97 Reaffirmed: CSAPH Rep. 3, A-07

(17) RESOLUTION 916 – WOMEN AND PRE-EXPOSURE PROPHYLAXIS (PrEP)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-20.985 be amended by addition to read as follows:

H-20.895 Pre-Exposure Prophylaxis for HIV

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV, including use in women and minority populations, and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. Res. 106, A-16

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-20.985 be adopted as amended in lieu of Resolution 916.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Policies H-20.922 and H-20.904 be reaffirmed.

HOD ACTION: Policy H-20.985 adopted as amended in lieu of Resolution 916 and Policies H-20.922 and H-20.904 reaffirmed.

Resolution 916 asks that our AMA 1. partner with the appropriate organizations to increase community awareness about Pre-exposure prophylaxis (PrEP) by developing a women-focused PrEP education and social marketing campaign aimed at reaching PrEP eligible women in the U.S., particularly women of color; 2. make readily available the current guidelines on Pre-exposure prophylaxis (PrEP) to increase knowledge and skills among family planning and other sexual and reproductive health care providers, particularly in areas with high HIV incidence; 3. encourage residency programs (e.g., Obstetrics and Gynecology, Family Medicine) to train future physicians to offer and administer HIV prevention services, including Pre-exposure prophylaxis (PrEP), and improve providers' ability to respond holistically to women living with and vulnerable to HIV; 4. encourage relevant organizations to develop training for physicians on HIV prevention services, including Pre-exposure prophylaxis (PrEP); and 5. encourage family planning, sexual health, and primary care providers to facilitate the integration of Pre-exposure prophylaxis (PrEP) services within clinics that serve HIV-vulnerable women and communities highly impacted by HIV.

Your Reference Committee heard testimony regarding the disproportionate number of minority women affected with HIV and the fact that PrEP is being prescribed more often in men than in women. Broad support for access to PrEP for women, especially in minority populations, was offered. Several amendments covering a variety of topics, such as addressing insurance coverage barriers, training, and access to PrEP in transgender individuals were offered. Your Reference Committee appreciates the amendments, but given the widespread support for the foundational concept of PrEP in women, believes that this resolution is best addressed with a simple amendment to Policy H-20.985, which was just adopted at A-16, and supports PrEP for HIV prevention. Your Reference Committee therefore recommends adoption of this amended policy, as well as reaffirmation of existing HIV prevention policy.

Policies recommended for reaffirmation:

H-20.922 HIV/AIDS as a Global Public Health Priority

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA: ... (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care. ... (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through prostitutes. ...

H-20.904 HIV/AIDS Education and Training

(1) Public Information and Awareness Campaigns...b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection. ... (3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers. Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies. ...

(18) RESOLUTION 917 – YOUTH INCARCERATION IN ADULT PRISONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 917, to read as follows:

YOUTH INCARCERATION IN ADULT FACILITIES

RESOLVED, That our American Medical Association support, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility; ~~legal reforms to address juveniles (less than 18 years of age) detained or incarcerated in adult facilities, including~~ 1. early intervention and rehabilitation services, 2. appropriate guidelines for parole, and 3. fairness in the expungement and sealing of records. (Directive to Take Action)

RESOLVED, That our AMA oppose the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policies H-60.919, H-60.986, and H-60.922 be reaffirmed.

HOD ACTION: Alternate resolution adopted as amended in lieu of Resolution 917 and Policies H-60.919, H-60.986, and H-60.922 reaffirmed.

Resolution 917 asks that our AMA 1. oppose incarceration of children (individuals less than 18 years of age) in adult prisons for non-violent crimes; 2. work with appropriate organizations to address age cutoffs for children (individuals less than 18 years of age) in adult prisons; 3. advocate for elimination of the incarceration of children (individuals less than 18 years of age) in adult prisons for non-violent crimes; 4. advocate for the passage of legislation that addresses reform for children (individuals less than 18 years of age) in adult prisons with respect to developing appropriate guidelines for parole, expungement and sealing of records, and solitary confinement; and 5. support early intervention and rehabilitation for children (individuals less than 18 years of age) that have been incarcerated in adult prisons.

Testimony was overwhelming supportive of the intent of this Resolution. It was noted that our AMA already has a number of existing policies addressing legal and judicial reforms to prevent the incarceration of children in adult prisons or pretrial confinement facilities. These existing policies were developed and informed by the Council on Science and Public Health's report on Juvenile Justice Reform (A-16), which specifically examined this issue. Our AMA also has existing policy on solitary confinement. However, current AMA policy does not address reforms for those children already incarcerated in adult facilities; therefore, your Reference Committee recommends that Resolution 917 be adopted as amended and existing policies on this issue be reaffirmed.

Policies recommended for reaffirmation:

H-60.919 Juvenile Justice System Reform

Our AMA: 1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system. 2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system. 3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age. 4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court. 5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to

prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems. 6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services. 7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community. 8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts. CSAPH Rep. 08, A-16.

H-60.986 Health Status of Detained and Incarcerated Youth

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care; (2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior. (3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided. (4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system. (CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

H-60.922 Solitary Confinement of Juveniles in Legal Custody

Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician. Res. 3, I-14 Reaffirmed: CSAPH Rep. 08, A-16.

(19) RESOLUTION 918 – ENSURING CANCER PATIENT ACCESS TO PAIN MEDICATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 918 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association policy, D-120.947, A More Uniform Approach to Assessing and Treating Patients with Controlled Substances for Pain Relief, be amended by addition as follows:

3. Our AMA will work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications in long-term care facilities and in the care of patients with cancer and cancer-related pain survivors, in much the same way as is being done for hospice and palliative care. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 918 be adopted as amended.

HOD ACTION: Resolution 918 adopted as amended.

Resolution 918 asks that our AMA:

- 1) Amend Policy D-120.947, "A More Uniform Approach to Assessing and Treating Patients with Controlled Substances for Pain Relief," by addition as follows:
 3. Our AMA will work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications in long-term care facilities and in the care of patients with cancer and cancer survivors, in much the same way as is being done for hospice and palliative care; and
- 2) Advocate and support advocacy at the state and federal levels against arbitrary prescription limits that restrict access to medically necessary treatment by limiting the dose, amount or days of the first or subsequent prescription for patients with pain related to a cancer or terminal diagnosis.

Although intended to target primary care clinicians, promulgation of the CDC Guidelines on the Use of Opioids for Chronic Pain has changed the clinical practice environment for pain management by influencing state legislation, as well as institutional and payer policies. Testimony highlighted unintended consequences including increasing difficulties experienced by patients, including cancer patients, in need of opioid-based pain management strategies. A need exists for the medical community to ensure that access to effective, opioid-based pain management is not compromised in these patients. The sponsor of the resolution clarified that the population of interest is really those with cancer-related pain, and not cancer survivors. Accordingly, your Reference Committee recommends that Resolution 918 be adopted as amended.

(20) RESOLUTION 919 – COAL-TAR BASED SEALCOAT THREAT TO HUMAN HEALTH AND THE ENVIRONMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 919 be amended by deletion, to read as follows:

RESOLVED, That our American Medical Association advocate for ~~national~~ legislation to ban the use of pavement sealcoats that contain polycyclic aromatic hydrocarbons (PAH) or requires at least, use of sealcoat products that contain ~~low or no minimal PAH, specifically products where the concentration of PAH is less than 1/1000th the concentration in coal-tar sealcoats.~~ (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 919 be adopted as amended.

HOD ACTION: Resolution 919 adopted as amended.

Resolution 919 asks that our AMA advocate for national legislation to ban the use of pavement sealcoats that contain polycyclic aromatic hydrocarbons (PAH); or at least, use sealcoat products that contain low or no PAH, specifically products where the concentration of PAH is less than 1/1000th the concentration in coal-tar sealcoats.

Your Reference Committee heard limited, but supportive and compelling testimony addressing the negative health and environmental consequences of polycyclic aromatic hydrocarbons (PAHs). It was noted that numerous state and local jurisdictions have banned PAHs. Your Reference Committee believes that AMA advocacy on this issue should not be limited to federal legislation, and also that the language should be broad and not specify a level that may not be evidence-based. Therefore, your Reference Committee recommends that Resolution 919 be adopted as amended.

(21) RESOLUTION 924 – AMA ADVOCACY FOR ENVIRONMENTAL SUSTAINABILITY AND CLIMATE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 924 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~develop a strategy to advocate for governments and other organizations~~ support initiatives to promote environmental sustainability and other efforts to halt global climate change (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 924 be amended by deletion, to read as follows:

RESOLVED, That our AMA incorporate principles of environmental sustainability within its ~~institutional mission and~~ business operations (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 924 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~offer programs to physicians to assist them~~ support physicians in adopting programs for environmental sustainability in their practices and ~~to help physicians to share these concepts with their patients and with their communities.~~ (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 924 be adopted as amended.

HOD ACTION: Resolution 924 adopted as amended.

Resolution 924 asks that our AMA 1. develop a strategy to advocate for governments and other organizations to promote environmental sustainability and other efforts to halt global climate change; 2. incorporate principles of environmental sustainability within its institutional mission and business operations; and 3. offer programs to physicians to assist them to adopt environmental sustainability in their practices and to help physicians to share these concepts with their patients and with their communities.

Your Reference Committee heard testimony mostly supportive of Resolution 924. Testimony in opposition noted that our AMA has existing policies and institutional programs that address this resolution. Your Reference Committee agrees that climate change is an important public health issue. However, given the numerous scientific resources that already exist on this issue, including reports developed by the World Health Organization and

resources specifically for physician practices, the AMA should support existing resources rather than offering our own programs. Therefore, your Reference Committee recommends that this resolution be adopted as amended.

(22) RESOLUTION 925 – GRAPHIC WARNING LABEL ON ALL CIGARETTE PACKAGES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that policy H-495.989 be amended by addition and deletion, to read as follows:

H-495.989 Tobacco Product Labeling

Our AMA:

(1) supports ~~working toward~~ requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States), ~~including the extension of labeling requirements of ingredients to tobacco products sold in the United States;~~ (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" and (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets. CSA Rep. 3, A-04 Modified: Res. 402, A-13

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Policy H-495.989 be adopted in lieu of Resolution 925.

HOD ACTION: Amended Policy H-495.989 adopted in lieu of Resolution 925.

Resolution 925 asks that our 1. AMA evaluate all opportunities for effective advocacy by organized medicine to require graphic warning labels depicting the dangers of smoking on all cigarette packages; and 2. endorse efforts of the Campaign for Tobacco Free Kids and the Food and Drug Administration to require tobacco companies to include graphic warning labels depicting the dangers of smoking on all cigarette packages.

Your Reference Committee heard testimony unanimously supporting the intent of Resolution 925. The FDA issued graphic warning labels in 2011, but the FDA rule was found to be in violation of the First Amendment. Since that time, the FDA has been sued by public health and medical groups to compel the agency to introduce a new graphic-warning rule. The AMA has existing policy supporting explicit and effective health warnings on tobacco products. Rather than adopting a separate policy on this issue, your Reference Committee recommends amending existing policy to incorporate the intent of this resolution.

(23) RESOLUTION 927 – THE DEA ORDER TO REDUCE OPIOID PRODUCTION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 927 be referred for decision.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 927 be amended by addition of a fourth Resolve, to read as follows:

RESOLVED, That 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.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the first and third Resolves of Resolution 927 be adopted, and that the fourth Resolve of Resolution 927 be adopted as amended.

HOD ACTION: The second Resolve of Resolution 927 referred for decision, first and third Resolves of Resolution 927 adopted, and that the fourth Resolve of Resolution 927 adopted as amended.

Resolution 927 asks that our American Medical Association 1. encourage relevant stakeholders to research the overall effects of opioid production cuts; 2. encourage the DEA to postpone any opioid production cuts until the potential effects of production quotas are better elucidated; and 3. encourage the DEA to be more transparent when developing medication production guidelines.

Considerable testimony was offered in support of Resolution 927 based on the belief that a reduction in the manufacturing quotas for schedule II opioids would lead to drug shortages, problems with access to opioid medications, and pain management disparities. There was agreement about a lack of transparency on the part of the Drug Enforcement Administration in making this type of decision and in the need to be vigilant about unintended consequences and the effects of quota reductions. While the agency has announced a 25% reduction in production quotas for most Schedule II opioids (33% for hydrocodone containing products), more than 10.5 billion dosage forms would still be available, and production quotas are subject to revision based on manufacturing issues and demand. Some concern was expressed about the optics of our AMA opposing the quota reduction (Resolve 2) given the nation's ongoing struggle with prescription opioid-related morbidity and mortality and its association with resurgence in heroin overdoses and deaths. Several speakers highlighted the need for physicians and other prescribers to play important roles in mitigating harm while preserving access to appropriate pain management, including opioid based treatment strategies. Therefore, your Reference Committee recommends several actions to address this issue in a measured fashion.

(24) RESOLUTION 901 – DISCLOSURE OF SCREENING TEST RISKS AND BENEFITS, PERFORMED WITHOUT A DOCTOR'S ORDER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 901 be referred.

HOD ACTION: Resolution 901 referred.

Resolution 901 asks that our AMA 1. advocate that if a screening test is being marketed as having a medical benefit and is offered and performed by a wellness program vendor without a specific order by the individual's physician or other licensed provider, they must provide the patient with the test specific evidence based guidance that supports the utility of the test; 2. advocate that if the procedure is not supported by specific evidence based guidance as a screening test for that patient and the patient still would like the screening test, the Wellness Program Vendor must offer the patient the opportunity to discuss the risks, benefits, and alternatives with a physician licensed to practice medicine in the state in which the test is being performed; 3. engage with federal regulators on whether vendors of health and wellness programs are in compliance with regulations applicable to marketing to patients in view of the impact of such programs on patients; and 4. continue to work with state medical societies, interested medical specialty societies and state agencies to provide public education regarding appropriate use of vendor wellness programs.

Multiple viewpoints were expressed on this resolution. Commercial vendors not connected with the patient's treating physician have invaded this space, based on profit-seeking motives. Patients do not understand the evidence base for many of the screening tests. Potential problems with broad use of the term "wellness program" were noted. Concerns were expressed about the operation of such vendors or organizations that promote such screening programs in an era of shared decision-making. Examples were presented where screening test visits have been used for the basis for billing the Medicare Annual Wellness visit and patients were unaware. Some speakers noted that these screen tests may be the only option available for underserved populations. Because of the complexity and important of this issue, considerable support was offered for referral. Your Reference Committee agrees but would like to emphasize the urgency of addressing this issue in a comprehensive manner.

Policy recommended for reaffirmation:

H-425.997 Preventive Services

1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective. 2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service. 3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician. BOT Rep. A, NCCMC Rec. 31, A-78 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report and Reaffirmed and Appended: CMS Rep. 7, A-00 Reaffirmed in lieu of Res. 104, A-06 Reaffirmation A-07 Modified and Reaffirmed: Sub. Res. 101, A-08

(25) RESOLUTION 906 – UNIVERSAL COLOR SCHEME FOR RESPIRATORY INHALERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 906 be referred.

HOD ACTION: Resolution 906 referred.

Resolution 906 asks that our AMA 1. work with leading respiratory inhaler manufacturing companies and health agencies such as the Federal Drug Administration and the American Pharmacists Association to develop consensus of a universal color scheme for short-acting beta-2 agonist respiratory inhalers that are used as "rescue inhalers" in

the United States; 2. work with leading respiratory inhaler manufacturing companies to ensure the universal color scheme for respiratory inhalers would allow for the least disruption possible to current inhaler colors, taking into account distribution of each brand and impact on current users if color were to change; and 3. work with leading respiratory inhaler manufacturing companies to ensure that universal color scheme for respiratory inhalers be designed for adherence and sustainability, including governance for future companies entering the respiratory inhaler market, and reserving colors for possible new drug classes in the future.

Your Reference Committee heard mixed testimony on the issue of color coding for respiratory inhalers. Testimony in support noted that this is a potentially practical approach that would potentially guarantee safety and help address patients with low health literacy. Testimony in opposition noted that this would be costly to implement and may not improve patient care. Your Reference Committee is aware that a previous CSA Report detailed the potential problems associated with color coding pharmaceutical products. The FDA's current draft guidance on "Safety Considerations for Container Labels and Carton Labeling Design to Minimize Medication Errors" recommends avoiding color coding in most instances. Problems have also been identified with the universal color coding system used in the United Kingdom, including what to do with combination drug inhalers. Therefore, your Reference Committee recommends referral for further study.

(26) RESOLUTION 907 – CLINICAL IMPLICATIONS AND POLICY CONSIDERATIONS OF CANNABIS USE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 907 be referred.

HOD ACTION: Resolution 907 referred.

Resolution 907 asks that our AMA:

- 1) Amend Policy H-95.998, "AMA Policy Statement on Cannabis," by deletion to read as follows: Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) ~~sale of cannabis should not be legalized;~~ (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use; and (4) (3) additional research should be encouraged; and
- 2) Amend Policy D-95.976 "Cannabis - Expanded AMA Advocacy," by deletion to read as follows: 1. Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available. 2. Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research. 3. Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a "public health", as contrasted with a "criminal," approach to cannabis. 4. Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. ~~It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States.~~"

Your Reference Committee heard testimony both in support of and in opposition to this Resolution. The Council on Science and Public Health spoke in support of referral, a recommendation that was supported by many others who testified. As growing numbers of states are legalizing both "medical" and the recreational use of cannabis, there is the need to support an effective regulatory framework in those jurisdictions. It was noted that the National Academy of Engineering, Science, and Medicine will be issuing a comprehensive report in January of 2017 on the health effects and therapeutic benefits of cannabis. Our AMA should review that report and update our policy accordingly. Therefore, your Reference Committee recommends referral.

(27) RESOLUTION 909 – PROMOTING RETROSPECTIVE AND COHORT STUDIES ON PREGNANT WOMEN AND THEIR CHILDREN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 909 be referred for decision.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-525.991 be reaffirmed.

HOD ACTION: Resolution 909 referred for decision and Policy H-525.991 reaffirmed.

Resolution 909 asks that our AMA 1. recommend to the US Department of Health and Human Services that the Federal Policy for the Protection of Human Subjects, or “Common Rule”, be updated to define pregnant women as “scientifically complex” rather than a “vulnerable population” for research purposes; and 2. urge the federal government to prioritize clinical research and generation and dissemination of data, emphasizing retrospective and cohort studies, on common medications’ effects on underlying medical conditions across the entire continuum from pregnancy through lactation and development to better inform prescribing. Additionally, Resolution 909 asks the AMA to support federal legislation to 1) establish an interagency taskforce within the Department of Health and Human Services to improve federal interagency and key stakeholder communication, coordination and collaboration to advance research on medications in pregnancy and breastfeeding, and 2) to require the United States Food and Drug Administration to provide regular reports to Congress tracking the inclusion of pregnant and breastfeeding women in clinical trials.

Your Reference Committee heard mixed testimony on this item. While there was support for mechanisms that would facilitate the inclusion of pregnant women in clinical research, others were confused about what it would mean for the conduct of clinical trials to reclassify pregnant women from “vulnerable” to “scientifically complex.” Others emphasized that the pregnant woman is not necessarily “vulnerable,” but that the protections of the “vulnerable” class are in place for the unborn fetus. Support for retrospective and cohort studies on common medications throughout the continuum of pregnancy throughout lactation was offered. Your Reference Committee is aware that AMA comments submitted on recent proposed changes to the Common Rule did not address the issue of pregnant women in research. Your Reference Committee believes that there is a need to determine the reasoning for not addressing pregnant women in the Common Rule comments, as well as to clarify what the term “scientifically complex” means, and suggests that the resolution be referred for decision so that these points can be clarified. However, because your Reference Committee supports the concept of research elucidating medication effects in pregnant women, it also recommends reaffirmation of Policy H-525.991, which encourages the inclusion of pregnant women in research when appropriate.

Policy recommended for reaffirmation:

H-525.991 Inclusion of Women in Clinical Trials

Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; (2) supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and (3) encourages translation of important research results into practice. Res. 183, I-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CSAPH Rep. 1, A-10 Modified: CSAPH Rep. 05, A-16

(28) RESOLUTION 920 – HAPTENATION AND HYPERSENSITIVITY DISORDERS COMMUNICATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 920 not be adopted.

HOD ACTION: Resolution 920 not adopted.

Resolution 920 asks that our AMA re-engage its communication efforts to make physicians aware of the process of haptentation and sensitization and their multiple ramifications, as well as to help physicians teach patients methods to avoid exposure to haptens, and to help physicians include chemical sensitivity in the differential diagnosis, take a history focused on exposures to toxins and symptoms related to known toxins and testing.

Your Reference Committee received mostly negative testimony on this resolution. The sponsor spoke to the existence of chemical sensitivity (a broader term for a “haptentation” disorder) as a pathophysiologic condition. Others testified that the resolution was complicated, and confused multiple issues. Your Reference Committee agrees that the evidence on this issue is limited and the resolution is confusing. Therefore, Your Reference Committee recommends that Resolution 920 not be adopted.

(29) RESOLUTION 928 – CLOSING THE LOOP ON PHARMACEUTICALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-135.925, H-135.936, and D-135.993 be reaffirmed in lieu of Resolution 928.

HOD ACTION: Policies H-135.925, H-135.936, and D-135.993 reaffirmed in lieu of Resolution 928.

Resolution 928 asks that our American Medical Association 1. take a leadership role in working with large, national chains and corporate conglomerates that dispense pharmaceutical drugs to address the growing and negative environmental impact caused by the improper disposal of these pharmaceutical drugs and their metabolites; 2. urge federal agencies to mandate pharmaceutical companies and retailers to take on the responsibility of taking back and properly disposing of outdated, expired, or unused drugs in an environmentally responsible and proper way; and 3. educate the public on the growing hazards and necessary methods to deal with the threat to our water systems posed by the improper disposal of pharmaceutical drugs and their metabolites.

Your Reference Committee heard limited testimony in support of the intent of this resolution. The AMA already has policy that addresses this resolution, broadly supporting efforts to safely dispose of unused medications (H-135.936). Policy also encourages the pharmaceutical industry to fund the programs (H-135.925) and supports changing laws or regulations to allow medication recycling and disposal to occur. Existing policy also addresses the potential environmental impacts of improper disposal, such as the contamination of drinking water (D-135.993). Therefore, your Reference Committee recommends reaffirmation of existing policy in lieu of Resolution 928.

Policies recommended for reaffirmation:

H-135.925 Medications Return Program

1. Our AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications. 2. Our AMA supports such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste. 3. Our AMA supports changes in federal law or regulation that would allow a program for medication recycling and disposal to occur. Res. 214, A-16

H-135.936 Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs

1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications. 2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. 3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling. Sub. Res. 515, A-10 Reaffirmation A-11 Appended: Res. 209, I-14

D-135.993 Contamination of Drinking Water by Pharmaceuticals and Personal Care Products

Our AMA supports the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems. Res. 403, A-06 Modified: CSAPH 01, A-16