

REFERRAL CHANGES AND OTHER REVISIONS (I-16)

REVISED REPORTS

- Report of the House of Delegates Committee on Compensation of the Officers

REVISED RESOLUTIONS

- Resolution 219 – Protect Individualized Compounding in Physicians' Offices as Practice of Medicine

MISCELLANEOUS

- Resolution 604 – Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere – Updated fiscal note: Variable, depending on whether existing contracts are affected.

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- Resolution 214 – Firearm-Related Injury and Death: Adopt a Call to Action (Michigan, American College of Surgeons)
- Resolution 604 – Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere (American Thoracic Society, American College of Preventive Medicine)

* Additional sponsors underlined.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials

Presented by: Peter H. Rheinstein, MD, JD, Chair
Sunday, November 13, 2016

1 Madam Speaker, Members of the House of Delegates:

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3 REAFFIRMATION RESOLUTIONS

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

- 14
- 15 • Resolution 205 AMA Study of the Affordable Care Act
 - 16 • Resolution 207 Limitation on Reports by Insurance Carriers to the National
17 Practitioner Data Bank Unrelated to Patient Care
 - 18 • Resolution 217 The Rights of Patients, Providers and Facilities to Contract for Non-
19 Covered Services
 - 20 • Resolution 218 Support for Prescription Drug Monitoring Programs
 - 21 • Resolution 222 Prohibition of Clinical Data Blocking
 - 22 • Resolution 801 Increasing Access to Medical Devices for Insulin-Dependent
23 Diabetics
 - 24 • Resolution 802 Eliminate "Fail First" Policy in Addiction Treatment
 - 25 • Resolution 808 A Study on the Hospital Consumer Assessment of Healthcare
26 Providers and Systems (HCAHPS) Survey and Healthcare Disparities
 - 27 • Resolution 810 Medical Necessity of Breast Reconstruction and Reduction Surgeries
 - 28 • Resolution 813 Physician Payment for Information Technology Costs
 - 29 • Resolution 815 Preservation of Physician-Patient Relationships and Promotion of
30 Continuity of Patient Care
 - 31 • Resolution 816 Support for Seamless Physician Continuity of Patient Care
 - 32 • Resolution 819 Nonpayment for Unspecified Codes by Third Party Payers
 - 33 • Resolution 902 Removing Restrictions on Federal Public Health Crisis Research
 - 34 • Resolution 916 Women and Pre-Exposure Prophylaxis (PrEP)
 - 35 • Resolution 921 Raise the Minimum Age of Legal Access to Tobacco to 21 Years
 - 36 • Resolution 922 Responsible Parenting and Access to Family Planning
 - 37 • Resolution 923 Reverse Onus in the Manufacture and Use of Chemicals
 - 38 • Resolution 924 AMA Advocacy for Environmental Sustainability and Climate

Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Naiim Ali, MD; Cheryl Gibson-Fountain, MD; Michael Hoover, MD; J. Fred Ralston, Jr., MD; Charles W. Van Way, MD; and Cyndi J. Yag-Howard, MD.

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Page 2

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Vermont

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Research

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Tennessee

* Alternate Delegate

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU, WITH CURRENT AMA POLICY AND ACTIVITIES – PAGE 3

- Resolution 205 - AMA Study of the Affordable Care Act
 - D-165.938, Redefining AMA's Position on ACA and Healthcare Reform
 - D-165.940, Monitoring the Affordable Care Act
 - H-165.835, AMA Advocacy for Health System Reform
 - H-165.828, Health Insurance Affordability
 - H-165.838, Health System Reform Legislation
 - D-165.984, Status Report On Expanding Coverage For The Uninsured
 - H-165.865, Principles for Structuring a Health Insurance Tax Credit
 - H-165.920, Individual Health Insurance
 - H-165.844, Educating the American People About Health System Reform
 - H-165.841, Comprehensive Health System Reform
 - H-165.845, State Efforts to Expand Coverage to the Uninsured
 - H-373.998, Patient Information and Choice
 - H-165.839, Health Insurance Exchange Authority and Operation
 - H-165.852, Health Savings Accounts
 - H-165.846, Adequacy of Health Insurance Coverage Options
 - In addition, the goals of Resolution 205 have been met by numerous AMA reports examining and identifying what needs to be changed or improved with the ACA; by numerous reports summarizing AMA advocacy and Congressional actions on fixes or improvements to the ACA pursuant to D-165.938; and ongoing AMA advocacy activities, as follows:
 - Redefining the AMA's Position on ACA and Healthcare Reform: BOT Rep. 6-I-13; BOT Rep. 24-A-14; BOT Rep. 2-I-14; BOT Rep. 22-A-15; BOT Rep. 4-I-15; BOT Rep. 7-A-16; BOT Rep. 4-I-16
 - CMS Report 5-I-13, Monitoring the Affordable Care Act
 - CMS Report 9-A-14, Improving the Affordable Care Act
 - CMS Report 8-I-15, Health Insurance Affordability
 - CMS Report 6-I-11, Health Insurance Exchanges
 - CMS Report 9-A-11, Covering the Uninsured and Individual Responsibility
 - CMS Policy Briefs on Health Insurance Market Reforms, available on the AMA website, at <http://www.ama-assn.org/ama/pub/advocacy/topics/health-insurance-market-reforms.page>, covering the following topics: Improving the Health Insurance Marketplace, Strategies to foster healthy markets; Improving the Health Insurance Marketplace, Health insurance subsidies; Health Insurance Exchanges; Individual Responsibility; Guaranteed issue and renewability; Modified Community Rating; Essential Health Benefits; Patient Navigators; Basic Health Program; Network Adequacy; Improving Health Insurance Affordability
 - AMA Comment Letter on CMS Proposed Notice of Benefit and Payment Parameters for 2018
 - AMA Comment Letter on Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces
 - AMA Comment Letter on Proposed Notice of Benefit and Payment Parameters for 2017
 - AMA Comment Letter on Proposed Notice of Benefit and Payment Parameters for 2016
- Resolution 207 - Limitation on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care
 - H-355.975, Opposition to the National Practitioner Data Bank
 - H-355.979, National Practitioner Data Bank
 - In addition, the goal of Resolution 207 has been achieved in the April 2015 revision to the NPDB Guidebook. As a result of AMA advocacy, the Guidebook states on page

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU, WITH CURRENT AMA POLICY AND ACTIVITIES – PAGE 4

E-16 that “A payment made as a result of a suit or claim solely against an entity...that does not identify an individual practitioner should not be reported to the NPDB...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.” (emphasis added)

- Letter to Ms. Ernia Hughes, Acting Director, Division of Practitioner Data Banks, Health Resources and Services Administration advocating for revisions to the NPDB Guidebook
- Resolution 217 - The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services
 - H-390.849, Physician Payment Reform
- Resolution 218 - Support for Prescription Drug Monitoring Programs
 - H-95.945, Prescription Drug Diversion, Misuse and Addiction
 - In addition, ongoing AMA advocacy activities also cover the goals of Resolution 218 including:
 - At the state level, AMA advocacy has supported efforts by states to enact legislation authorizing interstate interconnectivity between PDMPs.
 - AMA has supported efforts by the National Association of Boards of Pharmacy InterConnect program, which provides the technological platform for interstate interconnectivity. Currently, InterConnect has more than 30 state PDMPs using its system, and this number should continue to increase in 2017.
 - AMA letter to Energy and Commerce Committee on H.R. 1725
 - AMA letter to Senate Committee on Health, Education, Labor and Pensions on the National All Schedules Prescription Electronic Reporting Reauthorization Act (NASPER).
- Resolution 222 - Prohibition of Clinical Data Blocking
 - D-478.972, EHR Interoperability
 - In addition, the goal of Resolution 222 has been met by numerous AMA letters and documents including:
 - AMA Comment Letter to CMS on MACRA Proposed Rule
 - AMA Comment Letter on ONC Interoperability Roadmap for 2015
- Resolution 801 - Increasing Access to Medical Devices for Insulin-Dependent Diabetics
 - H-185.939, Value-Based Insurance Design
 - H-155.960, Strategies to Address Rising Health Care Costs
 - D-330.928, Strategies to Strengthen the Medicare Program
 - In addition, the AMA is prioritizing the prevention of type 2 diabetes within its strategic focus area aiming to improve health outcomes. The AMA is collaborating with key stakeholders to develop new approaches to prevent progression of prediabetes to type 2 diabetes. Also, recent AMA advocacy efforts have called for improvements to Medicare Advantage for patients living with multiple chronic conditions. Specifically, the AMA has stated that Medicare Advantage plans should be allowed and encouraged to provide coverage for services pursuant to new payment and delivery models that improve care for beneficiaries with multiple chronic conditions.
- Resolution 802 - Eliminate "Fail First" Policy in Addiction Treatment
 - D-120.938, Prior Authorization Simplification and Standardization
 - In addition, the AMA developed model legislation on medication assisted treatment (MAT) to provide a comprehensive approach to substance abuse treatment. This

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU, WITH CURRENT AMA POLICY AND ACTIVITIES – PAGE 5

model bill, “Ensuring Access to Medication Assisted Treatment Act,” provides that MAT should not be subject to step therapy, fail first or other similar drug utilization strategies or policies that may conflict with a health care professional’s prescribed course of treatment. Section VII of model bill, “Ensuring Transparency in Prior Authorization Act,” also defines limitations on health plans’ use of step therapy.

- Resolution 808 - A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities
 - H-450.966, Quality Management
 - D-385.958, Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment
 - H-450.982, Patient Satisfaction and Quality of Care
- Resolution 810 - Medical Necessity of Breast Reconstruction and Reduction Surgeries
 - H-320.995, Medical Necessity Determinations
 - H-320.953, Definitions of "Screening" and "Medical Necessity"
- Resolution 813 - Physician Payment for Information Technology Costs
 - D-330.909, Study the Costs of Administrative and Regulatory Burdens
 - D-478.996, Information Technology Standards and Costs
 - In addition, the AMA partnered with Dartmouth-Hitchcock in a 2015 joint research project to establish the amount of time that physicians spend on administrative tasks vs. 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 16 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 was published in the Annals of Internal Medicine in September, 2016 (See <http://annals.org/article.aspx?articleid=2546704>).
- Resolution 815 - Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care
 - H-165.837, Protecting the Patient-Physician Relationship
 - H-390.849, Physician Payment Reform
 - H-373.998, Patient Information and Choice
 - H-285.954, Physician Decision-Making in Health Care Systems
 - H-225.946, Preserving Physician/Patient Relationships During Hospitalizations
 - In addition, Council on Medical Service Report 4-A-10 focuses specifically on protecting the patient-physician relationship. Furthermore, AMA advocacy on bundled payment models explicitly emphasizes physician leadership and voluntary participation in these models. For example, the letter to CMS regarding the Comprehensive Care for Joint Replacement model notes on page 5 that, “Only physicians can make the determination as to what types of care could effectively address patients’ needs and in which settings those care services can be delivered safely and successfully.”
- Resolution 816 - Support for Seamless Physician Continuity of Patient Care
 - D-160.945, Communication Between Hospitals and Primary Care Referring Physicians
 - H-225.946, Preserving Physician/Patient Relationships During Hospitalizations
 - H-230.982, Clinical Privileges - Model Medical Staff Bylaws
 - In addition, Council on Medical Service Report 6-A-16 addresses communication and care coordination between physicians in inpatient and outpatient settings.

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- Resolution 819 - Nonpayment for Unspecified Codes by Third Party Payers
 - H-70.914, Opposing Coverage Decisions Based Solely on ICD-10 Code Specificity
 - H-70.958, Medicare ICD-10 Coding Requirements

- Resolution 902 - Removing Restrictions on Federal Public Health Crisis Research
 - D-440.997, Support for Public Health
 - H-60.975, Political Influence and the NIH

- Resolution 916 - Women and Pre-Exposure Prophylaxis (PrEP)
 - H-20.922, HIV/AIDS as a Global Public Health Priority
 - H-20.904, HIV/AIDS Education and Training
 - H-20.895, Pre-Exposure Prophylaxis for HIV

- Resolution 921 - Raise the Minimum Age of Legal Access to Tobacco to 21 Years
 - H-495.986, Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes

- Resolution 922 - Responsible Parenting and Access to Family Planning
 - H-75.987, Reducing Unintended Pregnancy

- Resolution 923 - Reverse Onus in the Manufacture and Use of Chemicals
 - D-135.987, Modern Chemicals Policies
 - D-135.976, Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976
 - H-135.956 Human and Environmental Health Impacts of Chlorinated Chemicals
 - H-135.973, Stewardship of the Environment
 - H-135.942, Modern Chemicals Policies

- Resolution 924 - AMA Advocacy for Environmental Sustainability and Climate
 - H-135.938, Global Climate Change and Human Health
 - H-135.939, Green Initiatives and the Health Care Community

SUMMARY OF FISCAL NOTES (I-16)

BOT Report(s)

- 01 2016 AMA Advocacy Efforts: Informational report
- 02 AMA Support for State Medical Societies' Efforts to Implement MICRA-Type Legislation: Modest
- 03 Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing: Modest
- 04 Redefining the AMA's Position on the ACA and Healthcare Reform - Update: Informational report
- 05 IOM "Dying in America" Report: Minimal
- 06 Designation of Specialty Societies for Representation in the House of Delegates: Minimal
- 07 Supporting Autonomy for Patients with Differences of Sex Development: Minimal
- 08 Medical Reporting for Safety Sensitive Positions: Minimal
- 09 Product-Specific Direct-to-Consumer Advertising of Prescription Drugs: Minimal
- 10 AMA Initiatives on Pharmaceutical Costs: Informational report
- 11 2017 Strategic Plan: Informational report
- 12# Specialty Society Representation in the House of Delegates - Five Year Review: Minimal

CC&B Report(s)

- 01 Membership and Representation in the Organized Medical Staff Section - Updated Bylaws: Minimal
- 02 Bylaw Amendments Pertaining to Late Resolutions and Emergency Business: Minimal

CEJA Opinion(s)

- 01 Modernized Code of Medical Ethics: Informational Report
- 02 Ethical Practice in Telemedicine: Informational Report

CEJA Report(s)

- 01 Collaborative Care: Minimal
- 02 Competence, Self-Assessment and Self Awareness: Minimal
- 03 CEJA and House of Delegates Collaboration: Informational Report
- 04 Ethical Physician Conduct in the Media: Informational Report

CLRPD Report(s)

- 01 Minority Affairs Section and Integrated Physician Practice Section, Five-Year Reviews: Minimal

CME Report(s)

- 01 Access to Confidential Health Services for Medical Students and Physicians: Minimal

CMS Report(s)

- 01 Infertility Benefits for Veterans: Minimal
- 02 Health Care While Incarcerated: Minimal
- 03 Providers and the Annual Wellness Visit: Minimal
- 04 Concurrent Hospice and Curative Care: Minimal
- 05 Incorporating Value into Pharmaceutical Pricing: Minimal
- 06 Integration of Mobile Health Applications and Devices into Practice: Modest
- 07 Hospital Discharge Communications: Minimal

SUMMARY OF FISCAL NOTES (I-16)

CSAPH Report(s)

- 01 Urine Drug Testing: \$30,000
- 02 National Drug Shortages: Update: Informational Report
- 03 Genome Editing and its Potential Clinical Use: Minimal
- 04 Hormone Therapies: Off-Label Uses and Unapproved Formulations: Minimal

HOD Comm on Compensation of the Officers

- # Report of the House of Delegates Committee on Compensation of the Officers (REVISED Page 7): \$80,000 - see report.

Resolution(s)

- 001 Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel: Minimal
- 002 Living Organ Donation at the Time of Imminent Death: Modest
- 003 Study of the Current Uses and Ethical Implications of Expanded Access Programs: Modest
- 004 Addressing Patient Spirituality in Medicine: Minimal
- 005* No Compromise on AMA's Anti-Female Genital Mutilation Policy: Modest
- 006* Effective Peer Review: Modest
- 007* Fair Process for Employed Physicians: Minimal
- 008# Blood Donor Deferral Criteria Revisions: Modest
- 201 Removing Restrictions on Federal Funding for Firearm Violence Research: Modest
- 202 Inclusion of Sexual Orientation and Gender Identity Information in Electronic Health Records: Minimal
- 203 Universal Prescriber Access to Prescription Drug Monitoring Programs: Minimal
- 204 Seamless Conversion of Medicare Advantage Programs: Modest
- 205 AMA Study of the Affordable Care Act: Modest
- 206 Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers): Modest
- 207 Limitation on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care: Modest
- 208 MIPS and MACRA Exemption: Modest
- 209 Affordable Care Act Revisit: Modest
- 210 Automatic Enrollment into Medicare Advantage: Modest
- 211 Electronic Health Records: Minimal
- 212 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation: Minimal
- 213 SOAP Notes and Chief Complaint: Minimal
- 214 Firearm Related Injury and Death: Adopt a Call to Action: Minimal
- 215 Parental Leave: Estimated cost of \$31,000 to conduct a detailed literature review of the impact of various forms of leave on patient health. Evaluate relevant studies and identify data sources needed to provide estimates. Estimate impacts and write-up results.
- 216* Ending Medicare Advantage Auto-Enrollment: Modest
- 217* The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services: Modest
- 218* Support for Prescription Drug Monitoring Programs: Minimal
- 219# Protect Individualized Compounding in Physicians' Offices as Practice of Medicine (REVISED): Modest
- 220# Distracted Driver Reduction: Modest
- 221# Electronic Medical Records Recovery Fee: Modest
- 222# Prohibition of Clinical Data Blocking: Minimal
- 223# Emergency Post-Election Support for Principles of the Patient Protection and Affordable Care Act: Minimal

SUMMARY OF FISCAL NOTES (I-16)

Resolution(s)

- 224# Protecting Patient Access to Health Insurance and Affordable Care: Modest
- 225# Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care: Modest
- 226# Continuing AMA Advocacy on the Patient Protection and Affordable Care Act: Modest
- 301 Expanding the Treatment of Opiate Dependence Using Medication-Assisted Treatment by Physicians in Residency Training Programs: Minimal
- 302 Protecting the Rights of Breastfeeding Residents and Fellows: Modest
- 303 Primary Care and Mental Health Training in Residency: Minimal
- 304 Improving Access to Care and Health Outcomes: Minimal
- 305 Privacy, Personal Use and Funding of Mobile Devices: Minimal
- 306 Formal Leadership Training During Medical Education: Modest
- 307 Inappropriate Uses of Maintenance of Certification: Modest
- 308 Promoting and Reaffirming Domestic Medical School Clerkship Education: Modest
- 309 Development of Alternative Competency Assessment Models: Minimal
- 310 Maintenance of Certification and Insurance Plan Participation: Minimal
- 311 Prevent Maintenance of Certification Licensure and Hospital Privileging Requirements: Modest
- 312* Eliminating the Tax Liability for Payment of Student Loans: Modest
- 602 Equality: No significant fiscal impact
- 603 Support a Study on the Minimum Competencies and Scope of Medical Scribe Utilization: Moderate
- 604* Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere: UPDATED FISCAL NOTE - Variable, depending on whether existing contracts are affected
- 606# Promote Teen Health Week: Minimal
- 607# Analysis of American Board of Internal Medicine (ABIM) Finances: Minimal
- 801 Increasing Access to Medical Devices for Insulin-Dependent Diabetics: Modest
- 802 Eliminate "Fail First" Policy in Addiction Treatment: Minimal
- 803 Reducing Perioperative Opioid Consumption: Minimal
- 804 Parity in Reproductive Health Insurance Coverage for Same-Sex Couples: Minimal
- 805 Health Insurance Companies Should Collect Deductible from Patients After Full Payments to Physicians: Modest
- 806 Pharmaceutical Industry Drug Pricing is a Public Health Emergency: Minimal
- 807 Pharmacy Use of Medication Discontinuation Messaging Function: Modest
- 808 A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities: Modest
- 809 Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers: Minimal
- 810 Medical Necessity of Breast Reconstruction and Reduction Surgeries: Minimal
- 811 Opposition to CMS Mandating Treatment Expectations and Practicing Medicine: Modest
- 812 Enact Rules and Payment Mechanisms to Encourage Appropriate Hospice and Palliative Care Usage: Minimal
- 813 Physician Payment for Information Technology Costs: Modest
- 814* Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act: Modest
- 815* Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care: Minimal
- 816* Support for Seamless Physician Continuity of Patient Care: Modest
- 817# Brand and Generic Drug Costs: Modest
- 818# Improving Communications Among Health Care Clinicians: Modest
- 819# Nonpayment for Unspecified Codes by Third Party Payers: Minimal
- 820# Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing: Modest

SUMMARY OF FISCAL NOTES (I-16)

Resolution(s)

- 901 Disclosure of Screening Test Risks and Benefits, Performed Without a Doctor's Order: Modest
- 902 Removing Restrictions on Federal Public Health Crisis Research: Minimal
- 903 Prevention of Newborn Falls in Hospitals: Minimal
- 904 Improving Mental Health at Colleges and Universities for Undergraduates: Minimal
- 905 Chronic Traumatic Encephalopathy (CTE) Awareness: Modest
- 906 Universal Color Scheme for Respiratory Inhalers: Estimated cost of 22,000 (includes staffing and meeting costs) to convene a series of meetings with stakeholders, including the FDA, providers, and industry organizations, to develop consensus on a color scheme for inhalers. Encourage manufacturers to adopt the color scheme.
- 907 Clinical Implications and Policy Considerations of Cannabis Use: Minimal
- 908 Faith and Mental Health: Modest
- 909 Promoting Retrospective and Cohort Studies on Pregnant Women and Their Children: Modest
- 910 Disparities in Public Education as a Crisis in Public Health and Civil Rights: Minimal
- 911 Importance of Oral Health in Medical Practice: Minimal
- 912 Neuropathic Pain Recognized as a Disease: Minimal
- 913 Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems: Minimal
- 914 Needle / Syringe Disposal: Minimal
- 915 Women and Alzheimer's Disease: Modest
- 916 Women and Pre-Exposure Prophylaxis (PrEP): Estimated cost of \$41,000 for a social media campaign for PrEP Awareness
- 917 Youth Incarceration in Adult Prisons: Modest
- 918 Ensuring Cancer Patient Access to Pain Medication: Minimal
- 919 Coal-Tar Based Sealcoat Threat to Human Health and the Environment: Modest
- 920 Haptenation and Hypersensitivity Disorders Communication: Modest
- 921 Raise the Minimum Age of Legal Access to Tobacco to 21 Years: Minimal
- 922 Responsible Parenting and Access to Family Planning: Minimal
- 923 Reverse Onus in the Manufacture and Use of Chemicals: Minimal
- 924 AMA Advocacy for Environmental Sustainability and Climate: Modest
- 925* Graphic Warning Label on all Cigarette Packages: Modest
- 926# Establishing and Achieving National Goals to Eliminate Lead Poisoning and Prevent Lead Exposures to Children: Minimal.
- 927# The DEA Order to Reduce Opioid Production: Modest
- 928# Closing the Loop on Pharmaceuticals: Modest

Resolutions not for consideration

- 601 Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations: Minimal
- 605* Study of Models of Childcare Provided at Healthcare Institutions: Modest
- 821# Support the ONE KEY QUESTION Initiative to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies: Minimal

SUMMARY OF FISCAL NOTES (I-16)

*** contained in Handbook Addendum**

Minimal - less than \$1,000

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

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

**ORDER OF BUSINESS
SECOND SESSION**

**Sunday, November 13, 2016
8:00 AM**

- 1. Report of the Committee on Rules and Credentials - Peter H. Rheinstein, MD, JD, Chair**
- 2. Presentation, Correction and Adoption of Minutes of 2016 Annual Meeting**
- 3. Remarks of the Speaker - Susan R. Bailey, MD**
- 4. Announcement of Changes in Reference Committees**
- 5. Report(s) of the Board of Trustees - Patrice A. Harris, MD, Chair**
 - 01 2016 AMA Advocacy Efforts (Info. Report)
 - 02 AMA Support for State Medical Societies' Efforts to Implement MICRA-Type Legislation (B)
 - 03 Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing (B)
 - 04 Redefining the AMA's Position on the ACA and Healthcare Reform - Update (Info. Report)
 - 05 IOM "Dying in America" Report (Amendments to C&B)
 - 06 Designation of Specialty Societies for Representation in the House of Delegates (Amendments to C&B)
 - 07 Supporting Autonomy for Patients with Differences of Sex Development (Amendments to C&B)
 - 08 Medical Reporting for Safety Sensitive Positions (Amendments to C&B)
 - 09 Product-Specific Direct-to-Consumer Advertising of Prescription Drugs (K)
 - 10 AMA Initiatives on Pharmaceutical Costs (Info. Report)
 - 11 2017 Strategic Plan (Info. Report)
 - 12# Specialty Society Representation in the House of Delegates - Five Year Review (Amendments to C&B)
- 6. Report(s) of the Council on Constitution and Bylaws - Colette R. Willins, MD, Chair**
 - 01 Membership and Representation in the Organized Medical Staff Section - Updated Bylaws (Amendments to C&B)
 - 02 Bylaw Amendments Pertaining to Late Resolutions and Emergency Business (Amendments to C&B)
- 7. Report(s) of the Council on Ethical and Judicial Affairs - Ronald J. Clearfield, MD, Chair**
 - 01 Collaborative Care (Amendments to C&B)
 - 02 Competence, Self-Assessment and Self Awareness (Amendments to C&B)
 - 03 CEJA and House of Delegates Collaboration (Info. Report)
 - 04 Ethical Physician Conduct in the Media (Info. Report)
- 8. Opinion(s) of the Council on Ethical and Judicial Affairs - Ronald J. Clearfield, MD, Chair**
 - 01 Modernized Code of Medical Ethics (Info. Report)
 - 02 Ethical Practice in Telemedicine (Info. Report)
- 9. Report(s) of the Council on Long Range Planning and Development - Mary T. Herald, MD, Chair**
 - 01 Minority Affairs Section and Integrated Physician Practice Section, Five-Year Reviews (F)
- 10. Report(s) of the Council on Medical Education - Patricia L. Turner, MD, Chair**
 - 01 Access to Confidential Health Services for Medical Students and Physicians (C)

11. Report(s) of the Council on Medical Service - Peter S. Lund, MD, Chair

- 01 Infertility Benefits for Veterans (J)
- 02 Health Care While Incarcerated (J)
- 03 Providers and the Annual Wellness Visit (J)
- 04 Concurrent Hospice and Curative Care (J)
- 05 Incorporating Value into Pharmaceutical Pricing (J)
- 06 Integration of Mobile Health Applications and Devices into Practice (J)
- 07 Hospital Discharge Communications (J)

12. Report(s) of the Council on Science and Public Health - S. Bobby Mukkamala, MD, Chair

- 01 Urine Drug Testing (K)
- 02 National Drug Shortages: Update (Info. Report)
- 03 Genome Editing and its Potential Clinical Use (K)
- 04 Hormone Therapies: Off-Label Uses and Unapproved Formulations (K)

13. Report(s) of the HOD Committee on Compensation of the Officers - Anthony M. Padula, MD, Chair

- # Report of the House of Delegates Committee on Compensation of the Officers (REVISED Page 7) (F)

--EXTRACTION OF INFORMATIONAL REPORTS--

14. Unfinished business

15. New Business (Introduction of Resolutions)

- 001 Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel (Amendments to C&B)
- 002 Living Organ Donation at the Time of Imminent Death (Amendments to C&B)
- 003 Study of the Current Uses and Ethical Implications of Expanded Access Programs (Amendments to C&B)
- 004 Addressing Patient Spirituality in Medicine (Amendments to C&B)
- 005* No Compromise on AMA's Anti-Female Genital Mutilation Policy (Amendments to C&B)
- 006* Effective Peer Review (Amendments to C&B)
- 007* Fair Process for Employed Physicians (Amendments to C&B)
- 008# Blood Donor Deferral Criteria Revisions (Amendments to C&B)
- 201 Removing Restrictions on Federal Funding for Firearm Violence Research (B)
- 202 Inclusion of Sexual Orientation and Gender Identity Information in Electronic Health Records (B)
- 203 Universal Prescriber Access to Prescription Drug Monitoring Programs (B)
- 204 Seamless Conversion of Medicare Advantage Programs (B)
- 205 AMA Study of the Affordable Care Act (B)
- 206 Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers) (B)
- 207 Limitation on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care (B)
- 208 MIPS and MACRA Exemption (B)
- 209 Affordable Care Act Revisit (B)
- 210 Automatic Enrollment into Medicare Advantage (B)
- 211 Electronic Health Records (B)

212 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation (B)
213 SOAP Notes and Chief Complaint (B)
214 Firearm Related Injury and Death: Adopt a Call to Action (B)
215 Parental Leave (B)
216* Ending Medicare Advantage Auto-Enrollment (B)
217* The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services (B)
218* Support for Prescription Drug Monitoring Programs (B)
219# Protect Individualized Compounding in Physicians' Offices as Practice of Medicine (REVISED) (B)
220# Distracted Driver Reduction (B)
221# Electronic Medical Records Recovery Fee (B)
222# Prohibition of Clinical Data Blocking (B)
223# Emergency Post-Election Support for Principles of the Patient Protection and Affordable Care Act (B)
224# Protecting Patient Access to Health Insurance and Affordable Care (B)
225# Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care (B)
226# Continuing AMA Advocacy on the Patient Protection and Affordable Care Act (B)
301 Expanding the Treatment of Opiate Dependence Using Medication-Assisted Treatment by Physicians in Residency Training Programs (C)
302 Protecting the Rights of Breastfeeding Residents and Fellows (C)
303 Primary Care and Mental Health Training in Residency (C)
304 Improving Access to Care and Health Outcomes (C)
305 Privacy, Personal Use and Funding of Mobile Devices (C)
306 Formal Leadership Training During Medical Education (C)
307 Inappropriate Uses of Maintenance of Certification (C)
308 Promoting and Reaffirming Domestic Medical School Clerkship Education (C)
309 Development of Alternative Competency Assessment Models (C)
310 Maintenance of Certification and Insurance Plan Participation (C)
311 Prevent Maintenance of Certification Licensure and Hospital Privileging Requirements (C)
312* Eliminating the Tax Liability for Payment of Student Loans (C)
602 Equality (F)
603 Support a Study on the Minimum Competencies and Scope of Medical Scribe Utilization (F)
604* Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere (F)
606# Promote Teen Health Week (F)
607# Analysis of American Board of Internal Medicine (ABIM) Finances (F)
801 Increasing Access to Medical Devices for Insulin-Dependent Diabetics (J)
802 Eliminate "Fail First" Policy in Addiction Treatment (J)
803 Reducing Perioperative Opioid Consumption (J)
804 Parity in Reproductive Health Insurance Coverage for Same-Sex Couples (J)
805 Health Insurance Companies Should Collect Deductible from Patients After Full Payments to Physicians (J)
806 Pharmaceutical Industry Drug Pricing is a Public Health Emergency (J)
807 Pharmacy Use of Medication Discontinuation Messaging Function (J)
808 A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities (J)

809 Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers (J)

810 Medical Necessity of Breast Reconstruction and Reduction Surgeries (J)

811 Opposition to CMS Mandating Treatment Expectations and Practicing Medicine (J)

812 Enact Rules and Payment Mechanisms to Encourage Appropriate Hospice and Palliative Care Usage (J)

813 Physician Payment for Information Technology Costs (J)

814* Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act (J)

815* Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care (J)

816* Support for Seamless Physician Continuity of Patient Care (J)

817# Brand and Generic Drug Costs (J)

818# Improving Communications Among Health Care Clinicians (J)

819# Nonpayment for Unspecified Codes by Third Party Payers (J)

820# Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing (J)

901 Disclosure of Screening Test Risks and Benefits, Performed Without a Doctor's Order (K)

902 Removing Restrictions on Federal Public Health Crisis Research (K)

903 Prevention of Newborn Falls in Hospitals (K)

904 Improving Mental Health at Colleges and Universities for Undergraduates (K)

905 Chronic Traumatic Encephalopathy (CTE) Awareness (K)

906 Universal Color Scheme for Respiratory Inhalers (K)

907 Clinical Implications and Policy Considerations of Cannabis Use (K)

908 Faith and Mental Health (K)

909 Promoting Retrospective and Cohort Studies on Pregnant Women and Their Children (K)

910 Disparities in Public Education as a Crisis in Public Health and Civil Rights (K)

911 Importance of Oral Health in Medical Practice (K)

912 Neuropathic Pain Recognized as a Disease (K)

913 Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems (K)

914 Needle / Syringe Disposal (K)

915 Women and Alzheimer's Disease (K)

916 Women and Pre-Exposure Prophylaxis (PrEP) (K)

917 Youth Incarceration in Adult Prisons (K)

918 Ensuring Cancer Patient Access to Pain Medication (K)

919 Coal-Tar Based Sealcoat Threat to Human Health and the Environment (K)

920 Haptentation and Hypersensitivity Disorders Communication (K)

921 Raise the Minimum Age of Legal Access to Tobacco to 21 Years (K)

922 Responsible Parenting and Access to Family Planning (K)

923 Reverse Onus in the Manufacture and Use of Chemicals (K)

924 AMA Advocacy for Environmental Sustainability and Climate (K)

925* Graphic Warning Label on all Cigarette Packages (K)

926# Establishing and Achieving National Goals to Eliminate Lead Poisoning and Prevent Lead Exposures to Children (K)

927# The DEA Order to Reduce Opioid Production (K)

928# Closing the Loop on Pharmaceuticals (K)

16. Presentation of Recommendations for Items of Business to Not be Considered at Interim Meeting

601 Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations (Not for consideration)

605* Study of Models of Childcare Provided at Healthcare Institutions (Not for consideration)

821# Support the ONE KEY QUESTION Initiative to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies (Not for consideration)

17. Report of the Committee on Rules and Credentials - Peter H. Rheinstein, MD, JD, Chair

** contained in the Handbook Addendum*

contained in the Sunday Tote

ORDER OF BUSINESS

Reference Committee on Amendments to Constitution and Bylaws (I-16)
John P. Abenstein, MD, Chair

November 13, 2016
Northern Hemisphere E3-4

Walt Disney World Swan and Dolphin Resort
Orlando

1. Board of Trustees Report 05 – IOM “Dying in America” Report
2. Board of Trustees Report 06 – Designation of Specialty Societies for Representation in the House of Delegates
3. Board of Trustees Report 07 – Supporting Autonomy for Patients with Differences of Sex Development
4. Board of Trustees Report 08 – Medical Reporting for Safety Sensitive Positions
5. Board of Trustees Report 12 – Specialty Society Representation in the House of Delegates - Five-Year Review
6. Council on Constitution & Bylaws Report 01 – Membership and Representation in the Organized Medical Staff Section – Updated Bylaws
7. Council on Constitution & Bylaws Report 02 – Bylaw Amendments Pertaining to Late Resolutions and Emergency Business
8. Council on Ethical and Judicial Affairs Report 01 – Collaborative Care
9. CEJA Report 02 – Competence, Self-Assessment and Self Awareness
10. Resolution 001 – Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel
11. Resolution 002 – Living Organ Donation at the Time of Imminent Death
12. Resolution 003 – Study of the Current Uses and Ethical Implications of Expanded Access Programs
13. Resolution 004 – Addressing Patient Spirituality in Medicine
14. Resolution 005 – No Compromise on Anti-Female Genital Mutilation Policy
15. Resolution 006 – Effective Peer Review

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16. Resolution 007 – Fair Process for Employed Physicians
17. Resolution 008 – Blood Donor Deferral Criteria Revisions

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ORDER OF BUSINESS

Reference Committee B (I-16)
Ann Stroink, MD, Chair

November 13, 2016
Southern Hemisphere 2

Dolphin Hotel
Orlando

1. Board Report 02—AMA Support for State Medical Societies' Efforts to Implement MICRA-type Legislation
2. Board Report 03—Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing
3. Resolution 203—Universal Prescriber Access to Prescription Drug Monitoring Programs
4. *Resolution 218—Support for Prescription Drug Monitoring Programs*
5. Resolution 201—Removing Restrictions on Federal Funding for Firearm Violence Research
6. Resolution 214—Firearm-Related Injury and Death: Adopt a Call to Action
7. 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
8. Resolution 204—Seamless Conversion of Medicare Advantage Programs
Resolution 210—Automatic Enrollment into Medicare Advantage
Resolution 216—Ending Medicare Advantage “Auto-Enrollment”
9. Resolution 206—Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers)
10. *Resolution 207—Limitation on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care*
Resolution 224—Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care
11. Resolution 208—MIPS and MACRA Exemptions
12. Resolution 211—Electronic Health Records
13. Resolution 213—SOAP Notes and Chief Complaint
14. Resolution 215—Parental Leave
15. *Resolution 217—The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services*
16. Resolution 219—Protect Individualized Compounding in Physicians' Offices as Practice of Medicine
17. Resolution 220—Distracted Driver Reduction
18. Resolution 221—Electronic Medical Recovery Fees
19. *Resolution 222—Prohibition of Clinical Data Blocking*
20. *Resolution 205—AMA Study of the Affordable Care Act*
Resolution 209—Affordable Care Act Revisit
Resolution 223—Emergency Post-Election Support for Principals of the Patient Protection and Affordable Care Act
Resolution 225—Continuing AMA Advocacy on the Patient Protection and Affordable Care Act
Resolution 226—Protecting Patient Access to Health Insurance and Affordable Care Act

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ORDER OF BUSINESS

Reference Committee C (I-16)
Martin D. Trichtinger, MD, Chair

November 13, 2016
Southern Hemisphere 4-5, Dolphin Tower

Walt Disney World Swan and Dolphin Resort
Orlando

1. Council on Medical Education Report 1, Access to Confidential Health Services for Medical Students and Physicians
2. Resolution 303, Primary Care and Mental Health Training in Residency
3. Resolution 301, Expanding the Treatment of Opiate Dependence Using Medication-Assisted Treatment by Physicians in Residency Training Programs
4. Resolution 302, Protecting the Rights of Breastfeeding Residents and Fellows
5. Resolution 304, Improving Access to Care and Health Outcomes
6. Resolution 305, Privacy, Personal Use and Funding of Mobile Devices
7. Resolution 306, Formal Leadership Training During Medical Education
8. Resolution 308, Promoting and Reaffirming Domestic Medical School Clerkship Education
9. Resolution 312, Eliminating the Tax Liability for Payment of Student Loans
10. Resolution 309, Development of Alternative Competency Assessment Models
11. Resolution 307, Inappropriate Uses of Maintenance of Certification

Resolution 311, Prevent Maintenance of Certification Licensure and Hospital Privileging Requirements
12. Resolution 310, Maintenance of Certification and Insurance Plan Participation

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ORDER OF BUSINESS

Reference Committee F (I-16)
Gary R. Katz, MD, Chair

November 13, 2016
Pacific Hall A-B

Walt Disney World Swan and Dolphin Resort
Orlando

1. Report of the House of Delegates Committee on the Compensation of the Officers
2. Council on Long Range Planning and Development Report 1 – Minority Affairs Section and Integrated Physician Practice Section, Five-Year Reviews
3. Resolution 602 – Equality
4. Resolution 604 – Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere
5. Resolution 603 – Support a Study on the Minimum Competencies and Scope of Medical Scribe Utilization
6. *Resolution 601 – Sexual Orientation and Gender Identity Demographic Collection by AMA and Other Medical Organizations*
7. *Resolution 605 – Study of Models of Childcare Provided at Healthcare Institutions*
8. Resolution 606 – Promote Teen Health Week
9. Resolution 607 – Analysis of American Board of Internal Medicine (ABIM) Finances

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

ORDER OF BUSINESS

Reference Committee J (I-16)
Candace E. Keller, MD, Chair

November 13, 2016
Southern Hemisphere 3

Walt Disney World Swan and Dolphin Resort
Orlando

1. Council on Medical Service Report 1 - Infertility Benefits for Veterans
2. Resolution 804 - Parity in Reproductive Health Insurance Coverage for Same-Sex Couples
3. Council on Medical Service Report 2 - Health Care while Incarcerated
4. Council on Medical Service Report 3 - Providers and the Annual Wellness Visit
5. 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
6. Council on Medical Service Report 6 - Integration of Mobile Health Applications and Devices into Practice
7. Council on Medical Service Report 7 - Hospital Discharge Communications
Resolution 818 - Improving Communications Among Health Care Clinicians
8. *Resolution 815 - Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care*
9. *Resolution 816 - Support for Seamless Physician Continuity of Patient Care*
10. *Resolution 808 - A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities*
11. Council on Medical Service Report 5 - Incorporating Value into Pharmaceutical Pricing
12. Resolution 806 - Pharmaceutical Industry Drug Pricing is a Public Health Emergency
13. Resolution 809 - Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers
14. Resolution 817 - Brand and Generic Drug Costs

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15. Resolution 803 - Reducing Perioperative Opioid Consumption
16. Resolution 807 - Pharmacy Use of Medication Discontinuation Messaging Function
17. *Resolution 813 – Physician Payment for Information Technology Costs*
18. *Resolution 801 - Increasing Access to Medical Devices for Insulin-Dependent Diabetics*
19. *Resolution 802 - Eliminating Fail First Policy in Addiction Treatment*
20. Resolution 814 - Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act
21. Resolution 805 - Health Insurance Companies Should Collect Deductible From Patients After Full Payments To Physicians
22. *Resolution 819 - Nonpayment for Unspecified Codes by Third Party Payers*
23. Resolution 820 - Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing
24. *Resolution 810 - Medical Necessity of Breast Reconstruction and Reduction Surgeries*
25. Resolution 811 - Opposition to CMS Mandating Treatment Expectations and Practicing Medicine
26. *Resolution 821 - Support the ONE KEY QUESTION® Initiative to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies*

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ORDER OF BUSINESS

Reference Committee K (I-16)
Paul A. Friedrichs, MD, Chair

November 13, 2016
Southern Hemisphere I – Dolphin

Walt Disney World Swan and Dolphin Resort
Orlando, FL

1. Board Of Trustees Report 9 - Product-Specific Direct-To-Consumer Advertising of Prescription Drugs
2. Council On Science And Public Health Report 3 - Genome Editing and its Potential Clinical Use
3. Council On Science And Public Health Report 4 - Hormone Therapies: Off-Label Uses and Unapproved Formulations
4. Council On Science And Public Health Report 1 - Urine Drug Testing
5. Resolution 918 – Ensuring Cancer Patient Access to Pain Medication
6. Resolution 912 – Neuropathic Pain Recognized as a Disease
7. Resolution 914 – Needle / Syringe Disposal
8. Resolution 906 – Universal Color Scheme for Respiratory Inhalers
9. Resolution 904 – Improving Mental Health at Colleges and Universities for Undergraduates
10. Resolution 908 – Faith and Mental Health
11. Resolution 915 – Women and Alzheimer's Disease
12. Resolution 905 – Chronic Traumatic Encephalopathy (CTE) Awareness
13. Resolution 910 – Disparities in Public Education as a Crisis in Public Health and Civil Rights
14. *Resolution 902 – Removing Restrictions on Federal Public Health Crisis Research*
15. Resolution 903 – Prevention of Newborn Falls in Hospitals
16. Resolution 909 – Promoting Retrospective and Cohort Studies on Pregnant Women and Their Children
17. *Resolution 922 – Responsible Parenting and Access to Family Planning*
18. Resolution 917 – Youth Incarceration in Adult Prisons
19. Resolution 911 – Importance of Oral Health in Medical Practice
20. Resolution 913 – Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems
21. *Resolution 916 – Women and Pre-Exposure Prophylaxis (PrEP)*
22. Resolution 901 – Disclosure of Screening Test Risks and Benefits, Performed Without a Doctor's Order
23. Resolution 920 – Haptension and Hypersensitivity Disorders Communication
24. Resolution 919 – Coal-Tar Based Sealcoat Threat to Human Health and the Environment
25. Resolution 928 – Closing the Loop on Pharmaceuticals
26. *Resolution 923 – Reverse Onus in the Manufacture and Use of Chemicals*
27. *Resolution 924 – AMA Advocacy for Environmental Sustainability and Climate*

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28. Resolution 926 – Establishing and Achieving National Goals to Eliminate Lead Poisoning and Prevent Lead Exposures to Children
29. Resolution 927 – The DEA Order to Reduce Opioid Production
30. *Resolution 921 – Raise the Minimum Age of Legal Access to Tobacco to 21 Years*
31. Resolution 925 – Graphic Warning Label on all Cigarette Packages
32. Resolution 907 – Clinical Implications and Policy Considerations of Cannabis Use

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Report of the AMPAC Board of Directors

Presented by: Robert Puchalski, MD
Chair

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

AMPAC Membership Fundraising

During the 2016 election cycle, AMPAC raised \$2,041,143 in hard dollars for candidate contributions. This amount, combined with AMPAC's corporate Political Education Fund receipts of \$350,000, brings the 2016 cycle total to \$2,391,143 which is comparable to the 2012 election cycle. AMPAC's direct fundraising hard dollar receipts increased by \$75,000 for a 9 percent increase over 2015 and are on track to surpass 2014 cycle hard dollar totals.

The House of Delegates (HOD) AMPAC participation is at 78 percent today - a 4 percent increase from where we ended in 2015. Additionally, the HOD AMPAC Capitol Club participation is at 46 percent which is up by 6 percent over the last election cycle. Our efforts will continue to focus on expanding HOD participation, especially in Capitol Club, since it will be critical to our efforts as we head into the next election cycle. Your personal participation, hopefully at the Capitol Club Silver level or higher, is very important.

AMPAC's Capitol Club participation continued to play a role in AMPAC's fundraising efforts. The Capitol Club program experienced steady growth compared to last year with 880 members. In particular, AMPAC's Capitol Club Platinum is at 79 members compared to last year's membership of 72, which is a 10% increase. All current 2016 Platinum members have been invited to attend an exclusive Red, White and Stu reception on Sunday, November 13 with guest Stu Rothenberg. Rothenberg is the founding editor and publisher of the Rothenberg & Gonzales Political Report, a non-partisan political newsletter covering U.S. House, Senate and gubernatorial campaigns, and presidential politics. All 2016 Capitol Club members are invited to AMPAC's luncheon on Monday, November 14. During this event the winner for our annual sweepstakes will be announced and the winner will enjoy an incredible Alaskan Land and Cruise trip. All current Platinum, Gold and Silver contributors are automatically entered into the sweepstakes drawing and just maybe you will be the lucky winner!

We need your continued support as leaders of the AMA. Moving into the next election cycle we can only be as effective as we are united in our efforts to support our own advocacy efforts. If you have not made a contribution to AMPAC for 2016 or would like to join for 2017, please stop by AMPAC's booth which is located in the AMA's exhibit area one level up from the House of Delegates meeting room.

Political Action

AMPAC played an important role in influencing 2016 election outcomes on behalf of medicine. Working together with state medical society PACs, AMPAC invested nearly \$2 million in the 2016 cycle. This included direct contributions to 348 physician-friendly candidates for the U.S. House and Senate from both political parties (58% to Republican lawmakers and 46% to Democratic lawmakers).

AMPAC also executed four independent expenditure campaigns on behalf of physician candidates: challengers Neal Dunn, MD (R, FL-02), Roger Marshall, MD (R, KS-01) and Rep. Joe Heck, DO (R, NV-SEN), and incumbent Rep. Ami Bera, MD (D, CA-07). Unlike in years past when AMPAC has focused IEs on broader “get out the vote” efforts, the goal in these races was to help them raise much needed campaign funds through an integrated mail and email solicitation program that reached over 56,000 physicians in all. After bruising primary contests, Dr. Dunn and Dr. Marshall had clear paths to victory on November 8. Both, however, had incurred significant primary debt that must be addressed quickly to prevent them from beginning the 2018 election cycle at a disadvantage. Doctors Bera and Heck were in two of the most tightly contested races in the country and needed every additional dollar possible in order to keep their campaign machinery running at top speed through the election.

The AMPAC IE program went three-for-four in 2016 as Dunn, Marshall and Bera all emerged victorious, while Heck ended up losing in one of the closer Senate races this cycle. From a broader perspective a total of 314 AMPAC supported candidates won election/reelection and the total number of physicians in Congress has dipped slightly from 17 and now stands at 14. This is due mainly to retirements and physician incumbents seeking other office. AMPAC’s total win rate in the 2016 cycle was 91%.

Political Education Programs

On February 18-19, AMPAC will host its 2017 Candidate Workshop at the AMA’s Washington, DC headquarters. A streamlined format will focus on helping AMA members develop the skills necessary to run for public office. The workshop will provide a hands-on learning experience and feature political experts from both sides of the aisle providing expert instruction in how to run a winning campaign. Sessions will include topics such as: effective fundraising techniques, crisis management, public speaking, grassroots organization and in general, how to run a disciplined campaign. Interested applicants should apply at ampaconline.org/apply.

As AMPAC continues to transform its political education programs to be more in tune with a 21st century learning environment, programing will expand to allow remote learning through online training modules. The future of the AMPAC Campaign Schools, Candidate Workshop, Regional Grassroots Seminars, and other programs will rely heavily on this new cutting-edge technology that will supplement in-person events with interactive instruction and coursework that physicians can do from the comfort of their own home on a computer or mobile device. You are encouraged to find out more about these exciting programs by coming by the AMPAC and AMA Grassroots booths during this meeting, or by visiting ampaconline.org.

Conclusion

On behalf of the AMPAC Board of Directors, I would like to thank all of our members for their continued involvement in political and grassroots activities. Just as we have a responsibility to care for our patients, we also have a duty to our profession and to our patients to assure that the interests of medicine are properly represented in the halls of Congress.

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 05 IOM "Dying in America" Report
- 06 Designation of Specialty Societies for Representation in the House of Delegates
- 07 Supporting Autonomy for Patients with Differences of Sex Development
- 08 Medical Reporting for Safety Sensitive Positions
- 12# Specialty Society Representation in the House of Delegates - Five Year Review

CC&B Report(s)

- 01 Membership and Representation in the Organized Medical Staff Section - Updated Bylaws
- 02 Bylaw Amendments Pertaining to Late Resolutions and Emergency Business

CEJA Report(s)

- 01 Collaborative Care
- 02 Competence, Self-Assessment and Self Awareness

Resolution(s)

- 001 Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel
- 002 Living Organ Donation at the Time of Imminent Death
- 003 Study of the Current Uses and Ethical Implications of Expanded Access Programs
- 004 Addressing Patient Spirituality in Medicine
- 005* No Compromise on AMA's Anti-Female Genital Mutilation Policy
- 006* Effective Peer Review
- 007* Fair Process for Employed Physicians
- 008# Blood Donor Deferral Criteria Revisions

* contained in Handbook Addendum

contained in Sunday Tote

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-16

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

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 The Board of Trustees (BOT) has completed its review of the specialty organizations seated in
2 the House of Delegates (HOD) scheduled to submit information and materials for the 2016
3 American Medical Association (AMA) Interim Meeting in compliance with the five-year
4 review process established by the House of Delegates in Policy G-600.020 and AMA
5 Bylaw 8.5.

6
7 Organizations are required to demonstrate continuing compliance with the guidelines
8 established for representation in the HOD. Compliance with the five responsibilities of
9 professional interest medical associations and national medical specialty organizations is also
10 required as set out in AMA Bylaw 8.2.

11
12 The following organizations were reviewed for the 2016 Interim Meeting:

13
14 American Academy of Insurance Medicine
15 American Academy of Sleep Medicine
16 American Society for Gastrointestinal Endoscopy
17 American Society for Radiation Oncology
18 American Society for Surgery of the Hand
19 American Society of Cytopathology
20 American Society of Plastic Surgeons
21 American Urological Association
22 AMSUS-The Society of Federal Health Professionals
23 North American Spine Society
24 Society for Vascular Surgery
25 Society of American Gastrointestinal and Endoscopic Surgeons
26

27 The American Association of Clinical Endocrinologists was also reviewed at this time as a
28 follow up to the 2016 AMA Annual Meeting review.

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

1 The materials submitted indicate that: the American Academy of Insurance Medicine,
2 American Association of Clinical Endocrinologists, American Society for Gastrointestinal
3 Endoscopy, American Society for Radiation Oncology, American Society for Surgery of the
4 Hand, American Urological Association, AMSUS-The Society of Federal Health Professionals,
5 North American Spine Society, Society for Vascular Surgery and Society of American
6 Gastrointestinal and Endoscopic Surgeons meet all guidelines and are in compliance with the
7 five-year review requirements of specialty organizations represented in the HOD.

8
9 **RECOMMENDATIONS**

10
11 The Board of Trustees recommends that the following be adopted and the remainder of this
12 report be filed:

- 13
14 1. That the American Academy of Insurance Medicine, American Association of Clinical
15 Endocrinologists, American Society for Gastrointestinal Endoscopy, American Society
16 for Radiation Oncology, American Society for Surgery of the Hand, American
17 Urological Association, AMSUS-The Society of Federal Health Professionals, North
18 American Spine Society, Society for Vascular Surgery, and Society of American
19 Gastrointestinal and Endoscopic Surgeons retain representation in the American
20 Medical Association House of Delegates. (Directive to Take Action)
21
22 2. Having failed to meet the requirements for continued representation in the AMA House
23 of Delegates as set forth in AMA Bylaw B-8.50, the American Academy of Sleep
24 Medicine, American Society of Cytopathology, and American Society of Plastic
25 Surgeons be placed on probation and be given one year to work with AMA membership
26 staff to increase their AMA membership. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX***Exhibit A - Summary Membership Information***

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Insurance Medicine	61 of 208 (30%)
American Academy of Sleep Medicine	956 of 5,303 (18%)
American Association of Clinical Endocrinologists	917 of 4,655 (20%)
American Society for Gastrointestinal Endoscopy	1,273 of 8,082 (16%)
American Society for Radiation Oncology	776 of 3,970 (20%)
American Society for Surgery of the Hand	439 of 2,015 (22%)
American Society of Cytopathology	205 of 1,246 (16%)
American Society of Plastic Surgeons	952 of 5,757 (16%)
American Urological Association	1,112 of 7,057 (16%)
AMSUS-The Society of Federal Health Professionals	660 of 2,219 (30%)
North American Spine Society	1,131 of 4,642 (24%)
Society for Vascular Surgery	560 of 2,585 (22%)
Society of American Gastrointestinal and Endoscopic Surgeons	921 of 4,112 (22%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020) and Professional Interest Medical Associations (G-600.022)

Policy G-600.020

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

Exhibit C

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

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

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

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

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

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

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

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

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

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

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

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of

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

8.6 Discontinuance of Representation. A specialty society or a professional interest medical association that has been granted representation in the House of Delegates will automatically have its representation terminated if it is not represented by a properly certified and seated delegate at 3 of 5 consecutive meetings of the House of Delegates. The specialty society or the professional interest medical association may continue as a member of the SSS pursuant to the provisions of the Standing Rules of the SSS, and may apply for representation in the House of Delegates after 3 additional years as a member of the SSS, under all of the provisions for a new application.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(I-16)

Introduced by: Medical Student Section

Subject: Blood Donor Deferral Criteria Revisions

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 Whereas, In December 2015, the FDA replaced its former policy that instituted a lifetime blood
2 ban for all men who have sex with men (MSM) with a policy that requires a 12-month deferral
3 period on blood donations since last MSM contact;¹ and
4

5 Whereas, Activists and researchers have criticized the 12-month deferral policy, stating it lacks
6 basis in scientific evidence and perpetuates stigma against members of the LGBTQ community,
7 and advocate for a more evidenced-based, holistic screening approach, such as Individual Risk
8 Assessment (IRA);^{2,3,4,5,6} and
9

10 Whereas, IRA screens for the risk factors of each potential donor based on set criteria, including
11 the use of HIV-prevention methods such as condoms and pre-exposure prophylaxis (PrEP),
12 number of sexual partners, relationship status, and intravenous drug use;^{4,5,6,7} and
13

14 Whereas, On June 12, 2016, the deadliest mass shooting in U.S. history occurred at PULSE, a
15 Florida LGBTQ nightclub, resulting in 49 deaths and leaving 53 individuals wounded and/or
16 critically injured;⁹ and MSM were reportedly turned away from donating blood to PULSE
17 shooting victims, preventing them to support members of their own community;^{9,10,11,12} and
18

19 Whereas, In July 2016, the FDA established a public docket on the Federal Register soliciting
20 commentary on scientifically and evidenced based methods, including IRA, to reevaluate and
21 update current blood banking practices;⁷ and
22

23 Whereas, In June 2016, a coalition of over 100 members of the U.S. House of Representatives
24 and 24 members of the U.S. Senate led a bipartisan effort to address current blood donor
25 criteria by sending letters that called on the FDA to develop better, non-discriminatory screening
26 protocols grounded in science like IRA;^{7,8,9} and

¹ Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products - Questions and Answers. United States Food and Drug Administration. December 21, 2015

² Halloran, L. Blood Ban Fix Continues to Fall Short of Acceptable Solution | Human Rights Campaign. Human Rights Campaign. December 21, 2015.

³ Zhou, L & Berkman, RW. Ban the ban: A scientific and cultural analysis of the FDA's ban on blood donations from men who have sex with men. Columbia Medical Review. 2016;1(1).

⁴ Kong, M. United States' Blood Donor Policy on Gay Men: Adopting an Italian Individual Risk Assessment Policy. Ann. Health L. Advance Directive. 2014;23:101-198.

⁵ Suligoi, B. et al. Changing blood donor screening criteria from permanent deferral for men who have sex with men to individual sexual risk assessment: no evidence of a significant impact on the human immunodeficiency virus epidemic in Italy. Blood Transfusion. 2013 Jul.; 11(3):441-8.

⁶ Schipani, V. Debate Over Gay Blood Donations. FactCheck.org. June 24, 2016.

⁷ US Food and Drug Administration: Blood Donor Deferral Policy for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products; Establishment of a Public Docket; Request for Comments, 81 Fed. Reg. § 145, (final rule July 22, 2016) (to be codified at 21 C.F.R. pt. 610)

⁸ Baldwin, T. et al. Letter to the FDA [Letter from US Senate to The Honorable Robert M. Califf, MD; US Food and Drug Administration]. United States Senate. June 20, 2016.

1 Whereas, Our AMA supports the use of rational, scientifically-based blood and tissue donation
 2 deferral periods that are fairly and consistently applied to donors according to their level of risk
 3 (H-50.973); and
 4

5 Whereas, Our AMA encourages the FDA to consider modifications to current exclusion policies
 6 if sufficient scientific evidence supports such changes (D-50.998); therefore be it
 7

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

10
 11 **Blood Donor Deferral Criteria H-50.973**

12 Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation
 13 deferral periods that are fairly and consistently applied to donors according to their level
 14 of individual risk; ~~and~~ (2) opposes the ~~current lifetime a~~ deferral on blood and tissue
 15 donations from men who have sex with men not based in science; and (3) supports
 16 research into Individual Risk Assessment criteria for blood donation. Modify Current
 17 HOD Policy)
 18

19 RESOLVED, That our AMA advocate for the elimination of current deferral policy and ask the
 20 Food and Drug Administration to develop recommendations for Individual Risk Assessment
 21 during the public commentary period. (New HOD Policy)

Date Received: 11/12/16

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

RELEVANT AMA POLICY

Blood Donor Deferral Criteria 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 risk; and (2) opposes the current lifetime deferral on blood and tissue donations from men who have sex with men. Res. 514, A-13

Blood Donor Recruitment D-50.998 – Our AMA shall encourage the Food and Drug Administration to continue evaluating and monitoring regulations on blood donation and to consider modifications to the current exclusion policies if sufficient scientific evidence supports such changes. Sub. Res. 401, A-02 Reaffirmed: CCB/CLRPD Rep. 4, A-12

Voluntary Donations of Blood and Blood Banking H-50.995 – Our AMA reaffirms its policy on voluntary blood donations (C-63); and directs attention to the need for adequate donor selection and post-transfusion follow-up procedures. Our AMA (1) endorses the FDA's existing blood policy as the best approach to assure the safety and adequacy of the nation's blood supply; (2) supports current federal regulations and legislation governing the safety of all blood and blood products provided they are based on sound science; (3) encourages the FDA to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United States; and (4) urges regulatory agencies and collection agencies to balance the implementation of new safety efforts with the need to maintain adequate quantities of blood to meet transfusion needs in this country. BOT Rep. V, A-71 Reaffirmed: CLRPD Rep. C, A-89 Appended: Res. 507, A-98 Appended: CSA Rep. 4, I-98 Reaffirmed: CSA Rep. 1, A-99 Amended & Appended: Res. 519, A-01 Modified: CSAPH Rep. 1, A-11

⁹ Quigley, M. et al. Letter to the FDA [Letter from US House of Representatives to The Honorable Robert M. Califf, MD; US Food and Drug Administration]. United States House of Representatives. June 20, 2016.

Blood Shortage and Collection H-50.990 – In response to a continuing need for blood for transfusion and decreasing supplies of allogeneic blood, our AMA supports programs that encourage donation of blood to the allogeneic supply by health volunteer donors; and the AMA encourages physicians to participate in promotional efforts to encourage blood donation, and urges the American Blood Commission to actively participate in these programs. Res. 41, A-82 Reaffirmed: CLRPD Rep. A, I-92 Modified by CSA Rep. 11, A-97 Reaffirmed: CSAPH Rep. 3, A-07

Safety of Blood Donations and Transfusions H-50.975 – Our AMA: (1) Supports working with blood banking organizations to educate prospective donors about the safety of blood donation and blood transfusion; (2) Supports the use of its publications to help physicians inform patients that donating blood does not expose the donor to the risk of HIV/AIDS; (3) Encourages physicians to inform high-risk patients of the value of self-deferral from blood and blood product donations; and (4) Supports providing educational information to physicians on alternatives to transfusion. CSA Rep. 4, A-03 Reaffirmed: CSAPH Rep. 1, A-13

Blood Banks H-50.999 – In recent years there has been a dramatic growth of blood banking facilities in the United States. The procurement of human blood and its transfusion to patients are medical procedures which require the direction and supervision of a physician. The ultimate objective of these procedures is the welfare of persons who require blood or blood derivatives. The medical profession has primary responsibility for the care and treatment of patients, and, therefore, has a paramount interest in evaluating facilities and procedures for blood procurement, storage and use. BOT Rep. I, I-63 Reaffirmed: CLRPD Rep. C, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CSAPH Rep. 2, A-08

Reference Committee B

BOT Report(s)

- 02 AMA Support for State Medical Societies' Efforts to Implement MICRA-Type Legislation
- 03 Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing

Resolution(s)

- 201 Removing Restrictions on Federal Funding for Firearm Violence Research
- 202 Inclusion of Sexual Orientation and Gender Identity Information in Electronic Health Records
- 203 Universal Prescriber Access to Prescription Drug Monitoring Programs
- 204 Seamless Conversion of Medicare Advantage Programs
- 205 AMA Study of the Affordable Care Act
- 206 Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers)
- 207 Limitation on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care
- 208 MIPS and MACRA Exemption
- 209 Affordable Care Act Revisit
- 210 Automatic Enrollment into Medicare Advantage
- 211 Electronic Health Records
- 212 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
- 213 SOAP Notes and Chief Complaint
- 214 Firearm Related Injury and Death: Adopt a Call to Action
- 215 Parental Leave
- 216* Ending Medicare Advantage Auto-Enrollment
- 217* The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services
- 218* Support for Prescription Drug Monitoring Programs
- 219# Protect Individualized Compounding in Physicians' Offices as Practice of Medicine (REVISED)
- 220# Distracted Driver Reduction
- 221# Electronic Medical Records Recovery Fee
- 222# Prohibition of Clinical Data Blocking
- 223# Emergency Post-Election Support for Principles of the Patient Protection and Affordable Care Act
- 224# Protecting Patient Access to Health Insurance and Affordable Care
- 225# Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care
- 226# Continuing AMA Advocacy on the Patient Protection and Affordable Care Act

* contained in Handbook Addendum

contained in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-16)

Introduced by: American Academy of Allergy, Asthma and Immunology
American College of Allergy, Asthma and Immunology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology–Head and Neck Surgery

Subject: Protect Individualized Compounding in Physicians' Offices
as Practice of Medicine

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, The AMA has adopted policy that encourages the United States Pharmacopeia (USP)
2 to retain special rules for compounding in physician offices for allergen immunotherapy and
3 potentially other kinds of small-volume physician office-based compounding, including engaging
4 with the U.S. Congress and the Food and Drug Administration (FDA); that the AMA shall form a
5 coalition of specialties impacted by rules related to physician in-office compounding; that
6 regulation of physician in-office compounding should be regulated by state medical boards
7 rather than state pharmacy boards; and that the AMA supports current 2008 USP General
8 Chapter <797> sterile compounding rules as pertaining to allergen extracts; and
9

10 Whereas, AMA Washington office staff have recently convened medical specialties affected by
11 recent proposed actions by the USP and FDA as they relate to physician office compounding
12 and are initiating a survey of the potential impact of proposed requirements on each specialty,
13 as well as assisting with outreach regarding broad concerns on this issue; and
14

15 Whereas, The USP’s revisions to Chapter <797> are not anticipated until at least 2018; and
16

17 Whereas, In August 2016, the FDA issued a draft guidance entitled “Insanitary Conditions at
18 Compounding Facilities” that effectively circumvents the USP Chapter <797> revision process
19 by indicating that states should enforce a set of standards for compounding facilities, including
20 considering to be insanitary any compounded material not mixed under those standards, and
21 specifically including physician in-office compounding in its definition of “compounding facilities”;
22 and
23

24 Whereas, The draft guidance specifically cites the 60 tragic deaths and 750 fungal meningitis
25 infections in 2012 resulting from contaminated products produced by a compounding pharmacy
26 and indicates that other adverse events have resulted from contaminated drug products
27 produced in commercial compounding facilities, but as yet the FDA has not provided evidence
28 or indication of any adverse events resulting from individually compounded medications
29 produced in physician offices; and specifically the FDA has not produced any data that allergen
30 extract compounding in physician offices has resulted in any infectious complications in
31 patients; and
32

33 Whereas, Any physician in the practice of Allergy/Immunology would have to consider
34 immediately halting treatment already underway for patients on allergen immunotherapy,
35 including those in treatment for allergies with a significant risk of life threatening anaphylaxis,

1 under threat of potential recourse by states implementing these standards as soon as a finalized
2 guidance might be issued, thereby putting these patients at serious risk of physical harm; and
3

4 Whereas, Allergen immunotherapy, which has been provided in the U.S. for more than 100
5 years with no known documented adverse infectious events, requires the allergist to compound
6 not only initial individualized treatment sets, but sometimes also to make modifications to a
7 patients' allergen extract over the course of this highly personalized treatment; and this
8 generally would not be possible under the standards suggested in the draft guidance, therefore
9 creating a significant barrier to the physician's ability to practice evidence based medicine; and
10

11 Whereas, The FDA's draft guidance, if made final, would thus have significant detrimental
12 impact on patients' access to optimal individualized care by limiting their physicians' ability to
13 practice medicine; and
14

15 Whereas, There is no known evidence that this effort by the FDA to expand compounding
16 pharmacy-level precautionary measures is indicated or necessary for small-volume physician in-
17 office compounding, and if FDA has such evidence that has not been shared then it is acting
18 without sufficient transparency for such an extraordinary regulatory over-reach; therefore be it
19

20 RESOLVED, That, using the Compounding Coalition organized by our American Medical
21 Association staff from AMA Policy H-120.930, "USP Compounding Rules," our AMA strongly
22 request that the US Food and Drug Administration withdraw its draft guidance "Insanitary
23 Conditions at Compounding Facilities" and that no further action be taken by the Agency until
24 revisions to the USP Chapter 19 <797> on Sterile Compounding, have been finalized. (Directive
25 to Take Action)

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

Received: 10/21/16

RELEVANT AMA POLICY

USP Compounding Rules H-120.930

1. Our AMA will engage in efforts to convince United States Pharmacopeia (USP) to retain the current special rules for procedures in the medical office that could include but not be limited to allergen extract compounding in the medical office setting and, if necessary, engage with the U.S. Food and Drug Administration (FDA) and work with the U.S. Congress to ensure that small volume physician office-based compounding is preserved.
2. Our AMA will undertake to form a coalition with affected physician specialty organizations such as allergy, dermatology, immunology, otolaryngology, oncology, ophthalmology, neurology, and rheumatology to jointly engage with USP, FDA and the U.S. Congress on the issue of physician office-based compounding preparations and the proposed changes to USP Chapter 797.
3. Our AMA reaffirms that the regulation of compounding in the physician office for the physician's patients be under the purview of state medical boards and not state pharmacy boards.
4. Our AMA supports the current 2008 USP Chapter 797 sterile compounding rules as they apply to allergen extracts, including specifically requirements related to the beyond use dates of compounded allergen extract stock.

Res. 204, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-16)

Introduced by: Georgia
Subject: Distracted Driver Reduction
Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, A higher percentage of U.S. drivers text or use hand-held cell phones while driving
2 compared to drivers in European countries; and
3
4 Whereas, Road fatalities, which had been dropping in the past years, are up roughly eight
5 percent in 2015 over the previous year; and
6
7 Whereas, One-fourth of all traffic accidents are associated with cell phone use; and
8
9 Whereas, Eight deaths and 1,161 injuries are reported to involve a distracted driver each day in
10 the U.S. per CDC estimates (i.e., a distracted driver is one driving while doing another activity
11 that tends to take the driver's attention away from driving); and
12
13 Whereas, Fourteen states and the District of Columbia have laws in place banning hand-held
14 cell phone use and texting; therefore be it
15
16 RESOLVED, That our American Medical Association develop model state legislation to limit cell
17 phone use to hands-free use only while driving. (Directive to Take Action)

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

Received: 10/20/16

RELEVANT AMA POLICY

The Dangers of Distraction While Operating Hand-Held Devices H-15.952

1. Our American Medical Association encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery.
 2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving.
 3. Our AMA: (A) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (B) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.
 4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.
 5. Our AMA: (A) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (B) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.
- Res. 217, I-08 Appended: Res. 905, I-09 Appended: BOT Rep. 10, A-13 Appended: Res. 416, A-13 Modified in lieu of Res. 414, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-16)

Introduced by: Georgia

Subject: Electronic Medical Records Recovery Fees

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, The Merit-Based Incentive Payment Systems and Alternate Payment Models under
2 the Medicare Access and CHIP Reauthorization Act are demanding access to quality measures
3 in various domains in electronic medical records (EMRs); and
4
5 Whereas, The EMRs being used may not be able to provide this access; and
6
7 Whereas, With the many different EMRs used by various hospitals and practices today not
8 providing the transparency that was one of the major reasons for implementing the EMR
9 system; and
10
11 Whereas, For these reasons stated above, as well as other reasons, a practice may wish to
12 change its EMR that has been used in patient care for any length of time; and
13
14 Whereas, The practice incurs an expense for access to its own data (e.g., patients' records)
15 held hostage by the original EMRs; and
16
17 Whereas, For this reason, the practice may elect to continue using an inferior EMR product; and
18
19 Whereas, This will negatively influence our ability to attain the original goals outlined for using
20 an EMR; therefore be it
21
22 RESOLVED, That our American Medical Association work to create legislation to be introduced
23 to the US Congress that would eliminate the costs to physicians associated with recovering
24 patient health care records from a previous electronic medical records (EMRs) vendor, when
25 they upgrade to a new EMR vendor. (Directive to Take Action)

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

Received: 10/20/16

RELEVANT AMA POLICY

EHR Interoperability D-478.972

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.
Sub. Res. 212, I-15

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
- Res. 730, I-04 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation A-10 Reaffirmed: BOT Rep. 16, A-11 Modified: BOT Rep. 16, A-11 Modified: BOT Rep. 17, A-12 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed: BOT Rep. 24, A-13 Reaffirmed in lieu of Res. 724, A-13 Appended: Res. 720, A-13 Appended: Sub. Res. 721, A-13 Reaffirmed: CMS Rep. 4, I-13 Reaffirmation I-13 Appended: BOT Rep. 18, A-14 Appended: BOT Rep. 20, A-14 Reaffirmation A-14 Reaffirmed: BOT Rep. 17, A-15 Reaffirmed in lieu of Res. 208, A-15 Reaffirmed in lieu of Res. 223, A-15 Reaffirmation I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-16)

Introduced by: New Mexico
Subject: Prohibition of Clinical Data Blocking
Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, In the past several years there have been a number of reports across the country of
2 hospital systems and integrated networks blocking the flow of clinical data from their electronic
3 health records (EHRs), a practice that some characterize as a tool used by some integrated
4 systems to coerce independent physicians to join them¹; and
5
6 Whereas, Some large EHR vendors such as Epic promote the concept of private in-network
7 information exchanges, facilitated by federal safe harbor rules that permit hospital networks to
8 subsidize up to 85 percent of the cost of EHR installation in an affiliated practice¹, while actively
9 discouraging data sharing out of network; and
10
11 Whereas, There was a published report of staff at an EHR vendor sales event suggesting that
12 the subsidy provided by that vendor was a good lure to get independent physicians to sell out,
13 because the alternative was meager information¹; and
14
15 Whereas, There are documented instances of physicians finding it impossible to gain access to
16 complete medical record information for their patients unless they became affiliated with the
17 hospital systems that controlled those patients' electronic health records; and
18
19 Whereas, Blocking the flow of clinical data is now considered to be one of the factors in
20 accelerating the trend towards consolidation of health care networks, with 285 hospital mergers
21 between 2011 and 2013, leading to less choice for physicians and patients, stifling competition,
22 and greatly increasing costs of care due to much higher fees paid to hospital owned clinics; and
23
24 Whereas, Attempts to implement successful statewide health information exchanges (HIEs) in a
25 number of states have been made more difficult, and those systems made less effective, by
26 clinical data blocking on the part of hospital based systems that only provide very limited data
27 sets, or no data at all, to the state HIE; and
28
29 Whereas, In 2015 and 2016 two states, Connecticut and Minnesota², have adopted legislation
30 that makes it illegal to use electronic health records to block the flow of clinical information; and
31
32 Whereas, Some EHR vendors, in particular eClinicalWorks, have gained notoriety by effectively
33 blocking data sharing by the imposition of exorbitant initial and recurrent charges to physician
34 groups for the implementation and ongoing use of electronic interfaces between their EHRs and
35 systems such as HIEs that make the data available to other physicians participating in the care
36 of shared patients; and

1 Whereas, It is extremely expensive for physician groups to change EHR vendors in a situation
2 where the vendor decides to impose exorbitant charges that make data sharing unaffordable;
3 and
4

5 Whereas, Interoperable sharing of clinical data is a central tenet of meaningful use and more
6 importantly, to the provision of timely, appropriate care; therefore be it
7

8 RESOLVED, That our American Medical Association advocate for the adoption of federal and
9 state legislation and regulations to prohibit health care organizations and networks from
10 blocking the electronic availability of clinical data to non-affiliated physicians who participate in
11 the care of shared patients, thereby interfering with the provision of optimal, safe and timely
12 care (New HOD Policy); and be it further
13

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

References:

¹ Connecticut law bans EHR-linked information blocking; Politico, October 30, 2015;
<http://www.politico.com/story/2015/10/connecticut-law-bans-ehr-linked-information-blocking-215400>

² Information Blocking Prohibited, Minnesota State Legislature, effective July 1, 2016;
https://www.revisor.mn.gov/bills/text.php?number=HF3580&version=latest&session=89&session_number=0&session_year=2015

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

Received: 10/22/16

RELEVANT AMA POLICY

EHR Interoperability D-478.972

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.

Sub. Res. 212, I-15

Principles for Hospital Sponsored Electronic Health Records D-478.973

1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

BOT Rep. 1, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-16)

Introduced by: Young Physicians Section

Subject: Emergency Post Election Support for Principles of the Patient Protection and Affordable Care Act

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

-
- 1 Whereas, Expanding health insurance coverage for all is a high priority of our AMA (D-165.955);
2 and
3
4 Whereas, The Congressional Budget office has estimated that a full repeal of the Patient
5 Protection and Affordable Care Act (PPACA) could add 22 million people to the ranks of the
6 uninsured within a two year transition window;¹ and
7
8 Whereas, Of those newly uninsured, the majority would be the populations covered by Medicaid
9 and the insurance marketplaces;¹ and
10
11 Whereas, Repeal of the PPACA could potentially undo significant progress already made in
12 expanding coverage to uninsured patients, preventing discrimination against patients based on
13 pre-existing conditions, expanding access to preventative health services, expanding coverage
14 under Medicaid to largely poor, minority, mentally ill, and other vulnerable and disadvantaged
15 citizens; and
16
17 Whereas, H.R. 3762 was passed by the House and Senate in 2015 but vetoed by President
18 Obama, and would have amended the PPACA by including sections such as: repealing tax
19 credits; eliminating the individual mandate; reducing Medicaid eligibility; and decreasing taxes
20 on medical devices, pharmaceutical companies, and health insurers, among other provisions;²
21 and
22
23 Whereas, President-elect Donald Trump has proposed repealing and replacing the PPACA
24 independently of the H.R. 3762 proposal; and
25
26 Whereas, The specific details of President-elect Donald Trump's plans for replacing PPACA
27 have not been unveiled, but have been noted to include: repealing the individual mandate,
28 creating a tax deduction as opposed to a tax credit, increasing access to international
29 pharmaceuticals, and enforcing immigration laws;³ and
30
31 Whereas, President-elect Donald Trump has indicated that states would be provided with block
32 Medicaid funding, but has not addressed whether there would be concurrent adjustments to
33 Medicare or a set minimum Medical Loss Ratio (MLR) to guide state spending;³ and
34
35 Whereas, President-elect Donald Trump has indicated that care would be preferentially
36 provided to those who maintained continuous healthcare coverage, and that states would
37 establish separate high-risk pools for those who did not maintain continuous coverage;³ and

1 Whereas, A Commonwealth Fund analysis estimated Trump's plan would raise the number of
2 uninsured Americans by 25 million and increase the federal budget by as much as \$41 million
3 largely due to his recommendation to eliminate the individual mandate to buy health insurance
4 in lieu of tax breaks intended for people to use to buy insurance;⁴ and

5
6 Whereas, 60 million Americans currently have pre-existing conditions, and may not be able to
7 obtain healthcare coverage if insurance companies can deny coverage based on such
8 conditions and allow medical underwriting;⁵ and

9
10 Whereas, Our AMA supports provisions of and modifications to the PPACA such as:

- 11 - Eliminating denials for pre-existing conditions (H-165.838)
- 12 - Study of approaches to decrease number of uninsured (H-165.882)
- 13 - Encouraging small businesses to offer insurance plans with exemptions and tax breaks
14 (H-165.882)
- 15 - Capping the tax exclusion for employment-based health insurance (H-165.828)
- 16 - Repeal of the Independent Payment Advisory Board (D-165.938)
- 17 - Seeking to ensure that federal health system reform include payment for the urgent and
18 emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or
19 its territories (H-165.904)
- 20 - Federal funding for the expansion of Medicaid to 138% of the federal poverty level in
21 states willing to accept expansion, as per current AMA policy (D-290.979); and

22
23 Whereas, Our AMA opposes reductions to particular benefits provided under the PPACA, such
24 as state and local public health funding (D-440.997); therefore be it

25
26 RESOLVED, That our American Medical Association make a public statement that any health
27 care reform legislation considered by Congress ensure continued improvement in patient
28 access to care and patient health insurance coverage by maintaining:

- 29 1) Guaranteed insurability, including those with pre-existing conditions, without medical
30 underwriting,
- 31 2) Income-dependent tax credits to subsidize private health insurance for eligible patients,
- 32 3) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in
33 states willing to accept expansion, as per current AMA policy (D-290.979),
- 34 4) Maintaining dependents on family insurance plans until the age of 26,
- 35 5) Coverage for preventive health services,
- 36 6) Medical loss ratios set at no less than 85% to protect patients from excessive insurance
37 costs. (Directive to Take Action)

Fiscal Note: Minimal – less that \$1,000.

Received: 11/11/16

References

¹ Washington, DC 20515 - Congressional Budget Office. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762senatepassed.pdf>. Accessed November 9, 2016.

² Text - H.R.3762 - 114th Congress (2015-2016): To provide for reconciliation pursuant to section 2002 of the concurrent resolution on the budget for fiscal year 2016. Congress.gov. <https://www.congress.gov/bill/114th-congress/house-bill/3762/text>. Accessed November 9, 2016.

³ Health Care Reform. <https://www.donaldjtrump.com/policies/health-care/>. Accessed November 9, 2016.

⁴ S. R. Collins, "The Health Care Reform Proposals of Hillary Clinton and Donald Trump," To the Point, The Commonwealth Fund, Sept. 23, 2016.

⁵ Sarah Kliff, "Trump does have an ObamaCare replacement plan - and it would cause 21 million to lose coverage." <http://www.vox.com/presidential-election/2016/11/9/13572834/trump-obamacare-replacement-plan>. Accessed November 9 2016.

RELEVANT AMA POLICY

Health Insurance Affordability H-165.828

1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).
 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.
 3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
 4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
 5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
 6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
 7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
- CMS Rep. 8, I-15 Reaffirmed in lieu of: Res. 121, A-16

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
 - a. Health insurance coverage for all Americans
 - b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
 - c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
 - d. Investments and incentives for quality improvement and prevention and wellness initiatives
 - e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
 - f. Implementation of medical liability reforms to reduce the cost of defensive medicine
 - g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
 - a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
 - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
 - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
 - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment

measurements that are not scientifically valid, verifiable and accurate

e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Sub. Res. 203, I-09 Reaffirmation A-10 Reaffirmed in lieu of Res. 102, A-10 Reaffirmed in lieu of Res. 228, A-10 Reaffirmed: CMS Rep. 2, I-10 Reaffirmed: Sub. Res. 222, I-10 Reaffirmed: CMS Rep. 9, A-11 Reaffirmation A-11 Reaffirmed: CMS Rep. 6, I-11 Reaffirmed in lieu of Res. 817, I-11 Reaffirmation I-11 Reaffirmation A-12 Reaffirmed in lieu of Res. 108, A-12 Reaffirmed: Res. 239, A-12 Reaffirmed: Sub. Res. 813, I-13 Reaffirmed: CMS Rep. 9, A-14 Reaffirmation A-15 Reaffirmed in lieu of Res. 215, A-15

Improving Access for the Uninsured and Underinsured H-165.882

Our AMA:

(1) Will assist state medical associations and local medical societies to work with states and the insurance industry to design value-based private group and individual health insurance policies. Such policies should cover with low cost-sharing those services adjudged to have the greatest health benefit, should be affordable, and should be equivalent to or an improvement over the Medicaid coverage in that state, so as to provide a continuum of gradually enhanced coverage.

(2) Supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. Any support for such small employer and voluntary purchasing cooperatives shall be strictly contingent upon safeguarding state and federal patient protections. For purposes of such legislation, small employers should be defined in terms of the number of lives insured, not the total number employed.

(3) Through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope.

(4) Supports continued study of all approaches to providing health services for the uninsured and cooperation with business groups to develop approaches that are best suited to the needs of small employers.

(5) Encourages physicians, through their local county medical societies, to explore ways to work within their communities to address the expanding problem of inadequate access to care for the uninsured and underinsured and openly communicate with one another to share information about successful programs.

(6) Will offer advice or assistance to states in advocating that the Consumer Operated and Oriented Plan (COOP) advisory board and HHS ensure that new insurance issuers, including those with physician involvement, benefit from start-up loans.

(7) Will take action to restore necessary funding for new health insurance co-operatives which had applied prior to enactment of the American Tax Relief Act of 2012, which eliminated this funding, and will work with the National Alliance of State Health Co-Ops (NASHCO) and other stakeholders to request the United States Congress and the US Department of Health and Human Services to re-establish funding to support new health insurance Co-Ops, which had applied prior to the enactment of the American Tax Relief Act of 2012.

CMS Rep. C, I-86 BOT Rep. JJ, A-89 Reaffirmed: Sub. Res. 110, A-94 Reaffirmed: CMS Rep. 6, I-96 CMS Rep. 7, A-97 Amended by CMS Rep. 9, A-98 Reaffirmation I-98 Reaffirmation A-99 Reaffirmed: CMS Rep. 5, I-99 Reaffirmed: Res. 238 and Reaffirmation A-00 Modified: BOT Rep. 17, I-00 Reaffirmation A-02 Res. 102, A-05 Consolidated: CMS Rep. 7, I-05 Modified: CMS Rep. 8, A-08 Reaffirmation A-09 Reaffirmation A-10 Reaffirmed in lieu of Res. 105, A-10 Reaffirmed: Res. 239, A-12 Appended: Res. 217, A-12 Appended: Res. 211, A-13

Medicaid Expansion D-290.979

Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.

Res. 809, I-12

Redefining AMA's Position on ACA and Healthcare Reform D-165.938

1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:

A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines;

B. Repeal and appropriate replacement of the SGR;

C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines;

D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting");

E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations;

F. Repeal the non-physician provider non-discrimination provisions of the ACA.

2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.

3. There will be a report back at each meeting of the AMA HOD.

Res. 231, A-13 Reaffirmed in lieu of Res. 215, A-15

Status Report on Expanding Health Care Coverage to all Individuals, with an Emphasis on the Uninsured D-165.955

1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all.

2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region.

CMS Rep. 1, I-05 Reaffirmed in lieu of Res. 101, A-13

Support for Public Health D-440.997

1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members? patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass.

2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes.

Res. 409, A-99 Modified CLRPD Rep. 1, A-03 Reaffirmed: CSAPH Rep. 1, A-13 Appended: Res. 206, A-13 Reaffirmation A-15

Universal Health Coverage H-165.904

Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans

Sub. Res. 138, A-94 Appended: Sub. Res. 109, I-98 Reaffirmation A-02 Reaffirmation A-07 Reaffirmation I-07 Reaffirmed: Res. 239, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-16)

Introduced by: Medical Student Section

Subject: Protecting Patient Access to Health Insurance and Affordable Care

Referred to: MSS Reference Committee B
(Ann R. Stroink, MD, Chair)

-
- 1 Whereas, Expanding health insurance coverage for all is a high priority of our AMA (D-165.955)
2 and our AMA opposes reductions to particular benefits provided under the Patient Protection
3 and Affordable Care Act (PPACA), such as state and local public health funding (D-440.997);
4 and
5
6 Whereas, The specific details of President-elect Donald Trump's plans for replacing PPACA
7 have not been unveiled, but have been noted to include: repealing the individual mandate,
8 creating a tax deduction as opposed to a tax credit, increasing access to international
9 pharmaceuticals, and enforcing immigration laws;¹ and
10
11 Whereas, President-elect Donald Trump has indicated that states would be provided with block
12 Medicaid funding, but has not addressed whether there would be concurrent adjustments to
13 Medicare or a set minimum Medical Loss Ratio (MLR) to guide state spending; and
14
15 Whereas, President-elect Donald Trump has indicated that care would be preferentially
16 provided to those who maintained continuous healthcare coverage, and that states would
17 establish separate high-risk pools for those who did not maintain continuous coverage; and
18
19 Whereas, One in two Americans may not be able to obtain healthcare coverage if insurance
20 companies can deny coverage based on pre-existing health conditions;² and
21
22 Whereas, Our AMA supports provisions of and modifications to the PPACA, such as:
23 - Eliminating denials for pre-existing conditions (H-165.838)
24 - Study of approaches to decrease number of uninsured (H-165.882)
25 - Encouraging small businesses to offer insurance plans with exemptions and tax breaks
26 (H-165.882)
27 - Capping the tax exclusion for employment-based health insurance (H-165.828)
28 - Repeal of the Independent Payment Advisory Board (D-165.938)
29 - Seeking to ensure that federal health system reform include payment for the urgent and
30 emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or
31 its territories (H-165.904)

¹ Health Care Reform. <https://www.donaldjtrump.com/policies/health-care/>. Accessed November 9, 2016.

² At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans. Office of the Assistant Secretary For Planning and Evaluation. US Department of Health and Human Services. <https://aspe.hhs.gov/pdf-report/risk-pre-existing-conditions-could-affect-1-2-americans>. Published November 1, 2011. Accessed November 11, 2016.

- 1 - Federal funding for the expansion of Medicaid to 138% of the federal poverty level in
 2 states willing to accept expansion, as per current AMA policy (D-290.979); therefore be it

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

Date Received: 11/12/16

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

RELEVANT AMA POLICY

Medicaid Expansion D-290.979 – Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.

Support for Public Health D-440.997 – 1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members/patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass. 2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes.

Health Insurance Affordability H-165.828 – 1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium

contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA). 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage. 3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy. 4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible. 5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. 6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges. 7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.

Health System Reform Legislation H-165.838 – 1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials d. Investments and incentives for quality improvement and prevention and wellness initiatives e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care f. Implementation of medical liability reforms to reduce the cost of defensive medicine. g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens 2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation. 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States. 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. 5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician. 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals. 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the

following provisions in health system reform legislation: a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy. 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform. 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal. 12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform. 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Improving Access for the Uninsured and Underinsured H-165.882 – Our AMA: (1) Will assist state medical associations and local medical societies to work with states and the insurance industry to design value-based private group and individual health insurance policies. Such policies should cover with low cost-sharing those services adjudged to have the greatest health benefit, should be affordable, and should be equivalent to or an improvement over the Medicaid coverage in that state, so as to provide a continuum of gradually enhanced coverage. (2) Supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. Any support for such small employer and voluntary purchasing cooperatives shall be strictly contingent upon safeguarding state and federal patient protections. For purposes of such legislation, small employers should be defined in terms of the number of lives insured, not the total number employed. (3) Through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope. (4) Supports continued study of all approaches to providing health services for the uninsured and cooperation with business groups to develop approaches that are best suited to the needs of small employers. (5)

Encourages physicians, through their local county medical societies, to explore ways to work within their communities to address the expanding problem of inadequate access to care for the uninsured and underinsured and openly communicate with one another to share information about successful programs. (6) Will offer advice or assistance to states in advocating that the Consumer Operated and Oriented Plan (COOP) advisory board and HHS ensure that new insurance issuers, including those with physician involvement, benefit from start-up loans. (7) Will take action to restore necessary funding for new health insurance co-operatives which had applied prior to enactment of the American Tax Relief Act of 2012, which eliminated this funding, and will work with the National Alliance of State Health Co-Ops (NASHCO) and other stakeholders to request the United States Congress and the US Department of Health and Human Services to re-establish funding to support new health insurance Co-Ops, which had applied prior to the enactment of the American Tax Relief Act of 2012.

H-165.904 Universal Health Coverage – 1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all. 2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-16)

Introduced by: Organized Medical Staff Section

Subject: Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

-
- 1 Whereas, The purpose of legislation establishing the National Practitioner Data Bank (NPDB)
2 was to improve health care quality, protect the public, and reduce health care fraud and abuse;
3 and
4
- 5 Whereas, The OMSS and others have been notified by physicians that they were named in
6 settled medical malpractice lawsuits and subsequently reported to the NPDB despite having no
7 involvement in the patient care that led to the lawsuit (e.g., physicians who were named as
8 defendants in a lawsuit due to their administrative capacities); and
9
- 10 Whereas, This type of unnecessary reporting to the NPDB is damaging to a physician's
11 reputation, employment status, hospital medical staff privileges, and future employment
12 opportunities; therefore be it
13
- 14 RESOLVED, That our American Medical Association seek legislation and/or regulation that
15 would require the Health Resources and Services Administration (HRSA) to clarify that reports
16 to the National Practitioner Data Bank (NPDB) of medical malpractice settlements by physicians
17 be limited to those cases in which the named physician was directly involved in the provision of
18 or failure to provide healthcare services (Directive to Take Action); and be it further
19
- 20 RESOLVED, That our AMA seek legislation and/or regulation that would require HRSA to audit
21 the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but
22 were reported as a result of a healthcare entity's settlement of a claim that included the names
23 of those physicians in their administrative roles at the entity (Directive to Take Action); and be it
24 further
25
- 26 RESOLVED, That our AMA seek legislation and/or regulation that would require HRSA to
27 remove reports from the NPDB of any physician who was reported as the result of the
28 settlement of a claim by a healthcare entity where the physician was not involved in the
29 treatment of the plaintiff (Directive to Take Action); and be it further
30
- 31 RESOLVED, That our AMA provide a report to the House of Delegates at the 2017 Interim
32 Meeting regarding our AMA's interactions with HRSA and detailing the actions taken or planned
33 by HRSA to eliminate inappropriate reporting of physicians to the NPDB. (Directive to Take
34 Action)

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

Received: 11/12/2016

RELEVANT AMA POLICY

H-355.975 Opposition to the National Practitioner Data Bank

1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank.
2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank.
3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office.
4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank.
5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;
6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.
7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least \$30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure.
8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates. (CCB/CLRPD Rep. 3, A-14)

H-355.974 National Practitioner Data Bank

1. Our AMA will advocate to the Health Resources and Services Administration that a physician's surrender of clinical privileges or failure to renew clinical privileges while under investigation should not be reported to the National Practitioner Data Bank unless the physician has been notified that an investigation is underway.
2. Our AMA: (a) recommends that medical staff bylaws require that physicians be notified in writing prior to the start of any investigation; and (b) include this recommendation in our AMA Physician's Guide to Medical Staff Organization Bylaws. (Res. 207, A-16)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-16)

Introduced by: Organized Medical Staff Section

Subject: Continuing AMA Advocacy on the Patient Protection and Affordable Care Act

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, The Patient Protection and Affordable Care Act (PPACA) is a comprehensive reform
2 law enacted in 2010 intended to increase health insurance coverage for the uninsured and
3 implement reforms to the health insurance market; and
4
5 Whereas, PPACA includes various provisions that are consistent with AMA policy and holds the
6 potential for a better health care system; and
7
8 Whereas, While the likelihood of the newly elected President's oft-repeated pledge to either
9 amend, repeal, or replace PPACA coming to pass remains unknown, the risk of interference
10 through executive action is imminent and may adversely impact our patients; and
11
12 Whereas, It is in the best interest of our patients that those portions of PPACA, which continue
13 to fulfill the standing policies of the AMA, remain intact; therefore be it
14
15 RESOLVED, That our American Medical Association actively and in a timely manner engage
16 the new Administration in discussions about the future of the Patient Protection and Affordable
17 Care Act, emphasizing the AMA's body of policy on health system reform. (Directive to Take
18 Action)

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

Received: 11/12/16

Reference Committee C

CME Report(s)

01 Access to Confidential Health Services for Medical Students and Physicians

Resolution(s)

- 301 Expanding the Treatment of Opiate Dependence Using Medication-Assisted Treatment by Physicians in Residency Training Programs
- 302 Protecting the Rights of Breastfeeding Residents and Fellows
- 303 Primary Care and Mental Health Training in Residency
- 304 Improving Access to Care and Health Outcomes
- 305 Privacy, Personal Use and Funding of Mobile Devices
- 306 Formal Leadership Training During Medical Education
- 307 Inappropriate Uses of Maintenance of Certification
- 308 Promoting and Reaffirming Domestic Medical School Clerkship Education
- 309 Development of Alternative Competency Assessment Models
- 310 Maintenance of Certification and Insurance Plan Participation
- 311 Prevent Maintenance of Certification Licensure and Hospital Privileging Requirements
- 312* Eliminating the Tax Liability for Payment of Student Loans

* contained in Handbook Addendum

contained in Sunday Tote

Reference Committee F

CLRPD Report(s)

01 Minority Affairs Section and Integrated Physician Practice Section, Five-Year Reviews

HOD Comm on Compensation of the Officers

Report of the House of Delegates Committee on Compensation of the Officers (REVISED Page 7)

Resolution(s)

602 Equality

603 Support a Study on the Minimum Competencies and Scope of Medical Scribe Utilization

604* Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere

606# Promote Teen Health Week

607# Analysis of American Board of Internal Medicine (ABIM) Finances

* contained in Handbook Addendum

contained in Sunday Tote

Compensation Committee Rep. I-16 -- page 7 of 9

1 Officers in leadership, the Board Chair, Chair-elect, President, President-elect and Immediate Past
 2 President have a significant level of responsibility, representing a time commitment well above that
 3 required by other non-profit Board leadership. This led to further analysis by the consultant to
 4 adjust for the variance in time commitment. This analysis showed that compensation for AMA
 5 Officers in leadership roles for the past three terms ranged near the median, resulting in the
 6 recommendation that leadership compensation continues to be appropriate and no change is
 7 necessary.

8
 9 RECOMMENDATIONS

10
 11 The Committee on Compensation of the Officers recommends the following recommendations be
 12 adopted and the remainder of this report be filed:

- 13
 14 1. That there be no change to the current Definitions effective July 1, 2012 as they appear in the
 15 Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per
 16 Diem for External Representation and Telephonic Per Diem for External Representation except
 17 for the Governance Honorarium and Per Diem amounts as recommended in 2, 3 and 4 below.
 18
- 19 • Definition of Governance Honorarium effective July 1, 2012:
 20 The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA
 21 work and related travel. This payment is intended to cover all currently scheduled Board
 22 meetings, special Board or Board committee meetings, task forces, subcommittees, Board
 23 orientation, development and media training, Board calls, sections, councils or other internal
 24 representation meetings or calls, and any associated review or preparatory work, and all travel
 25 days related to all meetings as noted above.
 26
 - 27 • Definition of Per Diem for Representation effective July 1, 2012:
 28 The purpose of this payment is to compensate for Board Chair-assigned representation day(s)
 29 and related travel for Officers, excluding Board Chairs and Presidents. Representation is either
 30 external to the AMA, or for participation in a group or organization with which the AMA has a
 31 key role in creating/partnering/facilitating achievement of the respective organization goals
 32 such as the AMA Foundation, PCPI, etc. The Board Chair may also approve a per diem for
 33 special circumstances that cannot be anticipated such as weather related travel delays.
 34
 - 35 • Definition of Telephonic Per Diem for External Representation effective July 1, 2011:
 36 Officers, excluding the Board Chairs and the Presidents, who are assigned as the AMA
 37 representative to outside groups as one of their specific Board assignments, receive a per diem
 38 rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or
 39 longer during a calendar day equal 2 or more hours. Payment for these meetings would require
 40 approval of the Chair of the Board.
 41
- 42 2. That the Governance Honorarium for all Board members excluding leadership, Board Chair,
 43 Board Chair-elect, President, President-elect, and Immediate Past President ~~Board Chairs~~ be
 44 increased effective July 1, 2017 to \$65,000. (Directive to Take Action)
 45
- 46 3. That the Per Diem for Chair-assigned representation external to the AMA or for participation
 47 in a group or organization with which the AMA has a key role in creating/partnering/facilitating
 48 achievement of the respective organization goals such as the AMA Foundation, PCPI, etc., and
 49 related travel be increased effective July 1, 2017 to \$1,300 per day. (Directive to Take Action)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(I-16)

Introduced by: Pennsylvania
Subject: Promote Teen Health Week
Referred to: Reference Committee F
(Gary R. Katz, MD, Chair)

- 1 Whereas, The rapid physical and emotional growth of adolescence differs from the needs of
2 children and adults and often includes deleterious, life-affecting choices of interpersonal
3 relationships, diet, exercise, self-harm, substance use, and violence; and
4
5 Whereas, Health behaviors resulting in adult morbidity and mortality are initiated in adolescence
6 and occur because teenagers are not exposed to positive activities which nurture better health
7 choices; and
8
9 Whereas, There are observances for specific teen health issues (e.g., Teen Dating Violence
10 Prevention Month, Teen Pregnancy Prevention Month, and Youth Violence Prevention Week)
11 but none for overall teen health; and
12
13 Whereas, AMA policy supports programs that encourage teen health and supports the
14 involvement of medical students, residents, and other physicians in educational efforts to
15 enhance teen health (AMA Policy H-170.972, The Role of Physicians in Improving Adolescent
16 Health); and
17
18 Whereas, Teen Health Week (January 9-13, 2017) has been organized by representatives of
19 the Delaware County (Pennsylvania) Medical Society, the Philadelphia College of Physicians,
20 the Pennsylvania Department of Education, and the Philadelphia County Medical Society, and
21 has been promoted by the South Eastern Pennsylvania Area Health Education Center; and
22
23 Whereas, The Pennsylvania Medical Society, at its annual House of Delegates meeting on
24 October 23, 2016, adopted the position to actively promote Teen Health Week
25 (January 9-13, 2017), and encourages state, county and specialty medical associations within
26 the Federation of Medicine across the nation to join, promote and participate in Teen Health
27 Week; and
28
29 Whereas, A Teen Health Week Toolkit has been developed to assist schools and other groups
30 in promoting active teen involvement in this effort; and
31
32 Whereas, The 2017 Teen Health Week, as well as future Teen Health Weeks, includes
33 publicized kick-off events at the Pennsylvania State Capitol with emphasis throughout the week
34 on nutrition and fitness, violence prevention, mental health, sexual health, and substance
35 abuse; and
36
37 Whereas, Pennsylvania's Teen Health Week remains the only such statewide observance in the
38 country; therefore be it

1 RESOLVED, That our American Medical Association actively promote Teen Health Week 2017
2 and encourage state medical associations and specialty medical associations across the nation
3 to join the initial efforts as originated in Pennsylvania, and encourage schools and other
4 appropriate organizations to adopt, promote and participate in Teen Health Week (Directive to
5 Take Action); and be it further
6

7 RESOLVED, That our AMA actively advocate, through direct communication with the
8 appropriate agencies and organizations, for the development of an annually recognized Teen
9 Health Week. (Directive to Take Action)

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

Received: 10/26/16

RELEVANT AMA POLICY

Role of Physicians in Improving Adolescent Health H-170.972

The AMA supports programs that encourage teen health and supports the involvement of medical students, residents, and other physicians in educational efforts to enhance teen health. Res. 431, A-94 Reaffirmed and Modified: CSA Rep. 6, A-04 Modified: CSAPH Rep. 1, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(I-16)

Introduced by: Pennsylvania

Subject: Analysis of American Board of Internal Medicine (ABIM) Finances

Referred to: Reference Committee F
(Gary R. Katz, MD, Chair)

1 Whereas, The American Board of Internal Medicine (ABIM), a 501(c)(3) organization, used \$56
2 million of diplomats' money to form another 501(c)(3) corporation known as the ABIM
3 Foundation; and
4

5 Whereas, The ABIM Foundation uses the income of the \$56 million for internal salaries, dubious
6 research which consistently publishes data in support of MOC, and approximately \$500,000 a
7 year for high-end retreats at the county's most expensive resorts; and
8

9 Whereas, The ABIM paid its President \$2,774,000 for her final 30 months of employment (an
10 annualized salary of \$1.1 million dollars); and
11

12 Whereas, The ABIM President gave her First Assistant a raise of \$103,000/year in 2011,
13 \$83,000/year in 2014, and a bonus of \$313,000 in 2011 for total earnings well in excess of
14 \$500,000; and
15

16 Whereas, The ABIM purchased a condominium for \$2.3 million and sold it for \$1.7 million losing
17 \$600,000 in cash along with real estate sales and transfer fees adding another loss of
18 approximately \$200,000, and chose to house its out-of-town guests in the most expensive per
19 square foot real estate in the city of Philadelphia as well as provide a chauffeur-driven limousine
20 for their use; and
21

22 Whereas, The top employees at the ABIM are receiving retirement contributions of 18 percent
23 per year (fully funded by the ABIM with no employee contributions) in contrast to the industry
24 average of five percent; and
25

26 Whereas, There may well be many more undiscovered excessive expenses at the ABIM;
27 therefore be it
28

29 RESOLVED, That our American Medical Association, prior to the end of December 2016,
30 formally, directly and openly ask the American Board of Internal Medicine (ABIM) if they would
31 allow an independent outside organization, representing ABIM physician stakeholders, to
32 independently conduct an open audit of the finances of both the American Board of Internal
33 Medicine (ABIM), a 501(c)(3) tax-exempt, non-profit organization, and its Foundation (Directive
34 to Take Action); and be it further
35

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

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

Fiscal Note: Minimal – less than \$500.

Received: 10/27/16

Reference Committee J

CMS Report(s)

- 01 Infertility Benefits for Veterans
- 02 Health Care While Incarcerated
- 03 Providers and the Annual Wellness Visit
- 04 Concurrent Hospice and Curative Care
- 05 Incorporating Value into Pharmaceutical Pricing
- 06 Integration of Mobile Health Applications and Devices into Practice
- 07 Hospital Discharge Communications

Resolution(s)

- 801 Increasing Access to Medical Devices for Insulin-Dependent Diabetics
- 802 Eliminate "Fail First" Policy in Addiction Treatment
- 803 Reducing Perioperative Opioid Consumption
- 804 Parity in Reproductive Health Insurance Coverage for Same-Sex Couples
- 805 Health Insurance Companies Should Collect Deductible from Patients After Full Payments to Physicians
- 806 Pharmaceutical Industry Drug Pricing is a Public Health Emergency
- 807 Pharmacy Use of Medication Discontinuation Messaging Function
- 808 A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities
- 809 Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers
- 810 Medical Necessity of Breast Reconstruction and Reduction Surgeries
- 811 Opposition to CMS Mandating Treatment Expectations and Practicing Medicine
- 812 Enact Rules and Payment Mechanisms to Encourage Appropriate Hospice and Palliative Care Usage
- 813 Physician Payment for Information Technology Costs
- 814* Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act
- 815* Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care
- 816* Support for Seamless Physician Continuity of Patient Care
- 817# Brand and Generic Drug Costs
- 818# Improving Communications Among Health Care Clinicians
- 819# Nonpayment for Unspecified Codes by Third Party Payers
- 820# Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing

* contained in Handbook Addendum

contained in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-16)

Introduced by: Georgia
Subject: Brand and Generic Drug Costs
Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

- 1 Whereas, The costs of brand and generic medications are rapidly rising; and
2
3 Whereas, The average annual cost of cancer drugs increased from roughly \$10,000 before
4 2000 to more than \$100,000 by 2012, according to a recent study in Mayo Clinic Proceedings;
5 and
6
7 Whereas, Several breakthrough specialty medications and orphan drugs recently approved by
8 the Food and Drug Administration (FDA) have subsequently entered the pharmaceutical market
9 with hefty price tags; and
10
11 Whereas, Biogen Idec's multiple sclerosis drug, Tecfidera, costs \$54,900 per patient per year;
12 hepatitis C medications from Gilead Sciences costs approximately \$84,000 per patient; and
13 Orkambi, a cystic fibrosis drug from Vertex Pharmaceuticals, is priced at \$259,000 per year; and
14
15 Whereas, For 222 generic drug groups prices increased by 100 percent or more between 2013
16 and 2014, according to *Forbes*; and
17
18 Whereas, Generic drugs have long provided payers some respite from other more expensive
19 products and services, rising prices in generics like Mylan NV's albuterol sulfate--which
20 increased about 4,000 percent from 2013 to 2014; and
21
22 Whereas, Seventy-three percent of Americans find the cost of drugs to be unreasonable, and
23 most blamed drug manufacturers for setting prices too high; and
24
25 Whereas, Some particularly high-cost medications for hepatitis C have even forced insurers and
26 Medicaid programs to limit usage of the drugs; and
27
28 Whereas, Recent disclosure of the rapid increase in the cost of EpiPen indicates a concern for
29 pricing of all medications; and
30
31 Whereas, Private payers, doctors, and Accountable Care Organizations should collaborate with
32 manufacturers on pharmacoeconomic studies in order to value the outcomes and financial
33 benefits brought to the health system by a therapeutic drug; and
34
35 Whereas, If providers are facing greater accountability in the form of bundled reimbursement,
36 pay-for-performance, and penalties for inadequate care, Big Pharma should share some of the
37 responsibility; and

1 Whereas, When a fairly priced product fails to yield the benefits quantified through joint
 2 pharmaco-economic studies, the producer should reimburse payers for the drug price, or lead
 3 corrective measures--like an additional treatment regimen--at no further cost to other
 4 stakeholders; and

5
 6 Whereas, Generic drugs in theory operate in a free market where competition regulates prices;
 7 and

8
 9 Whereas, For some drugs, the number of manufacturers may be small, thus putting this system
 10 at risk; and

11
 12 Whereas, In monopoly-like environments, regulators should set caps on price increases; and

13
 14 Whereas, Pharmaceutical firms in America enjoy a hands-off approach by government to pricing
 15 products, atypical by global standards; and

16
 17 Whereas, Medicare is barred from negotiating prices with manufacturers, and the FDA does not
 18 consider cost in the approval of a medication; and

19
 20 Whereas, Government agencies in Canada, Australia, and European countries can negotiate
 21 medication prices, often by conducting their own studies to evaluate therapeutic benefits;
 22 therefore be it

23
 24 RESOLVED, That our American Medical Association advocate for the following:

- 25
 26 1) Investigate the purchasing of medications from outside the country with FDA
 27 guidance, on a temporary basis until availability in the U.S. improves;
 28 2) Advocate to permit temporary compounding with FDA's guidance until medications
 29 are available;
 30 3) Advocate to allow increased competition in the marketing of medications;
 31 4) Advocate for participative pricing;
 32 5) Advocate for accountability for outcomes; and
 33 6) Advocate for increased regulation of the generic drug market. (New HOD Policy)

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

Received: 11/20/16

RELEVANT AMA POLICY

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

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

Cost of Prescription Drugs H-110.997

Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

BOT Rep. O, A-90 Sub. Res. 126 and Sub. Res. 503, A-95 Reaffirmed: Res. 502, A-98 Reaffirmed: Res. 520, A-99 Reaffirmed: CMS Rep. 9, I-99 Reaffirmed: CMS Rep.3, I-00 Reaffirmed: Res. 707, I-02 Reaffirmation A-04 Reaffirmed: CMS Rep. 3, I-04 Reaffirmation A-06 Reaffirmed in lieu of Res. 814, I-09 Reaffirmed in lieu of Res. 201, I-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-16)

Introduced by: Georgia

Subject: Improving Communications Among Health Care Clinicians

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

1 Whereas, With the massive changes in the delivery of health care over the last few years, as
2 electronic medical records (EMR), the advent of hospitalists being the primary care provider
3 (PCP) in the hospital, and the increasing amount of burdensome regulations that physicians and
4 hospitals deal with daily, it is clear that the art of communication between all aspects of the
5 health care spectrum has seen tremendous changes in the management of direct patient care;
6 and

7
8 Whereas, Though these changes are continuing, it is becoming that the art of communication
9 between physicians-physicians, physicians-hospital staff, and physicians-patients appear to
10 have only worsened resulting in higher health care costs, increased medical errors, and an
11 increase in medical malpractice suits due to poor communications, also known as “systems”
12 failure; and

13
14 Whereas, Several studies have pointed out that direct communication between physicians on a
15 particular patient during their hospitalization may be between three to 20 percent of the time;
16 and

17
18 Whereas, In one study, *Bell et al.* surveyed 1,772 PCPs for 1,078 hospitalized patients at six
19 academic centers--only 77 percent were aware of the patient’s hospitalization, and of that only
20 23 percent received direct communication about their patient during their hospital care; and

21
22 Whereas, Another study done by *Roy et al.* studied the communication between hospitalist
23 teams who assumed care from a previous hospitalist team found that only 43.7 percent of the
24 teams actually had a communication about the medical care of the same patients from the
25 previous team; and

26
27 Whereas, A later study again by *Roy et al.* looked into the barriers in communication between
28 hospitalists and a patient’s PCP and cited that hospitalists believed that they were too busy with
29 multiple patients, did not believe it would help with in-patient care, or were unclear who the
30 patient’s PCP actually was and did not have anyone find out; and

31
32 Whereas, The same study further provided that all these perceived barriers by hospitalists
33 suggest that the concept of continuity of aftercare has not been a priority; and

34
35 Whereas, In 2014, poor communication amongst providers in Texas resulted in a patient who
36 had traveled to an Ebola-endemic region being sent home from the emergency room; the
37 admitting nurse recorded this information, but none of the medical clinicians ever looked at it,
38 which resulted in the patient exposing more people to Ebola; and

1 Whereas, The number of cases being sent to medical boards as well as cases involved in
2 medical malpractice suits are increasing in number yearly and they are being labeled as
3 “systems” failures; and
4

5 Whereas, In order to improve the quality of care in today’s health care environment, there must
6 be a leader in the health care arena to change this increasing problem; and
7

8 Whereas, Physicians must take the lead to improve communication between all entities; state
9 medical associations and the AMA must take a leadership role to decrease these kinds of
10 unnecessary medical errors; therefore be it
11

12 RESOLVED, That our American Medical Association, in association with the American Hospital
13 Association, assess the national impact of communication barriers and their negative impact on
14 direct patient care in the hospital and after discharge between physician-physician in the
15 hospital, in-hospital and after discharge care, and physician-patients and report to our AMA
16 House of Delegates by the 2017 Interim Meeting (Directive to Take Action); and be it further
17

18 RESOLVED, That our AMA research and develop guidelines that physicians can initiate in their
19 communities to improve communication between physician-physician in the hospital, hospital
20 and after discharge care, and physician-patients and report to our AMA House of Delegates by
21 the 2017 Interim Meeting. (Directive to Take Action)

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

Received: 10/20/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-16)

Introduced by: Georgia

Subject: Nonpayment for Unspecified Codes by Third Party Payers

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

- 1 Whereas, The Department of Health and Human Services' Centers for Medicare & Medicaid
2 Services (CMS) required the use of ICD-10 diagnosis codes to replace ICD-9 codes as of
3 October 1, 2015; and
4
- 5 Whereas, Certain third party payers have stated their intent to deny payment for unspecified
6 ICD-10 codes, with elimination of their grace period as of October 1, 2016; and
7
- 8 Whereas, It is impossible to avoid using unspecified codes if the practitioner wants to be
9 accurate and truthful; and
10
- 11 Whereas, Requiring specific codes in all circumstances requires the practitioner to code
12 inaccurately and untruthfully in certain circumstances, contributing to inaccurate data collection,
13 contrary to the purpose of ICD-10 code implementation; and
14
- 15 Whereas, The CMS website clearly states that unspecified codes are necessary in many
16 situations (e.g., "In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have
17 acceptable, even necessary, uses); and
18
- 19 Whereas, Physicians should report specific diagnosis codes when they are supported by
20 available medical record documentation and clinical knowledge of the patient's health condition,
21 but in some instances signs/symptoms or unspecified codes are the best choice to accurately
22 reflect the health care encounter; and
23
- 24 Whereas, Physicians should code each health care encounter to the level of certainty known for
25 that particular encounter; and
26
- 27 Whereas, If a definitive diagnosis has not been established by the end of the encounter, it is
28 appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis; and
29
- 30 Whereas, When sufficient clinical information is not known or available about a particular health
31 condition to assign a more specific code, it is acceptable to report the appropriate unspecified
32 code (for example, a diagnosis of pneumonia has been determined but the specific type has not
33 been determined); and
34
- 35 Whereas, In fact, you should report unspecified codes when such codes most accurately reflect
36 what is known about the patient's condition at the time of that particular encounter; and

1 Whereas, It is inappropriate to select a specific code that is not supported by the medical record
2 documentation or to conduct medically unnecessary diagnostic testing to determine a more
3 specific code; therefore be it
4

5 RESOLVED, That our American Medical Association advocate to the Centers for Medicare &
6 Medicaid Services and the America's Health Insurance Plans for insurance reform that would
7 not penalize physicians and other health care practitioners financially or otherwise from using
8 unspecified codes when appropriate. (New HOD Policy)

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

Received: 10/20/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-16)

Introduced by: Pennsylvania

Subject: Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

1 Whereas, Insurers often retrospectively refuse payment for studies and testing that do not
2 routinely require prior authorization; and
3
4 Whereas, Insurers use medical policies that are not routinely updated to reflect the ever-
5 changing practice guidelines; and
6
7 Whereas, Insurers use medical codes as a method to limit and deny payment for services that
8 otherwise would be covered; and
9
10 Whereas, Many rare and uncommon disease states require testing and studies otherwise
11 reserved for populations in which screening is the standard of care; and
12
13 Whereas, An example of denied coverage referenced in the aforementioned is: osteopenia and
14 osteoporosis are well documented complications of Sickle Cell Disease (SCD); and
15
16 Whereas, Many studies have shown that DEXA scans are necessary to diagnose, follow up on,
17 and treat osteopenia and osteoporosis in children and adults with SCD; and
18
19 Whereas, The medical policies of most insurers do not include SCD as an approved indication
20 for DEXA scan coverage; and
21
22 Whereas, Insurers, based on these incomplete medical policies, continue to deny coverage for
23 DEXA scans in children and adults with SCD; and
24
25 Whereas, Physicians, hospital systems and other health care professionals spend an inordinate
26 amount of time and resources resubmitting, appealing and/or going through other unnecessary
27 processes to secure payment for many studies and testing appropriately prescribed and
28 indicated for rare and uncommon disease states; and
29
30 Whereas, Many hospital systems are forced to “write off” the costs of these studies and tests
31 due to insurers’ denial of payment based on flawed medical policies; therefore be it
32
33 RESOLVED, That our American Medical Association advocate for legislation to require insurers’
34 medical policies to reflect current evidence-based medically appropriate studies and treatments
35 including those for rare and uncommon diseases (Directive to Take Action); and be it further

1 RESOLVED, That our AMA advocate for legislation to require insurers to implement a
2 streamlined process for exceptions for rare or uncommon disease states (Directive to Take
3 Action); and be it further
4

5 RESOLVED, That our AMA advocate for legislation to prohibit insurers from using medical
6 coding as the sole justification to deny medical services and diagnostic or therapeutic testing.
7 (Directive to Take Action)

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

Received: 10/26/16

Reference Committee K

BOT Report(s)

09 Product-Specific Direct-to-Consumer Advertising of Prescription Drugs

CSAPH Report(s)

01 Urine Drug Testing

03 Genome Editing and its Potential Clinical Use

04 Hormone Therapies: Off-Label Uses and Unapproved Formulations

Resolution(s)

901 Disclosure of Screening Test Risks and Benefits, Performed Without a Doctor's Order

902 Removing Restrictions on Federal Public Health Crisis Research

903 Prevention of Newborn Falls in Hospitals

904 Improving Mental Health at Colleges and Universities for Undergraduates

905 Chronic Traumatic Encephalopathy (CTE) Awareness

906 Universal Color Scheme for Respiratory Inhalers

907 Clinical Implications and Policy Considerations of Cannabis Use

908 Faith and Mental Health

909 Promoting Retrospective and Cohort Studies on Pregnant Women and Their Children

910 Disparities in Public Education as a Crisis in Public Health and Civil Rights

911 Importance of Oral Health in Medical Practice

912 Neuropathic Pain Recognized as a Disease

913 Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems

914 Needle / Syringe Disposal

915 Women and Alzheimer's Disease

916 Women and Pre-Exposure Prophylaxis (PrEP)

917 Youth Incarceration in Adult Prisons

918 Ensuring Cancer Patient Access to Pain Medication

919 Coal-Tar Based Sealcoat Threat to Human Health and the Environment

920 Haptenation and Hypersensitivity Disorders Communication

921 Raise the Minimum Age of Legal Access to Tobacco to 21 Years

922 Responsible Parenting and Access to Family Planning

923 Reverse Onus in the Manufacture and Use of Chemicals

924 AMA Advocacy for Environmental Sustainability and Climate

925* Graphic Warning Label on all Cigarette Packages

926# Establishing and Achieving National Goals to Eliminate Lead Poisoning and Prevent Lead Exposures to Children

927# The DEA Order to Reduce Opioid Production

928# Closing the Loop on Pharmaceuticals

* contained in Handbook Addendum

contained in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 926
(I-16)

Introduced by: American Association of Public Health Physicians
The Endocrine Society
National Medical Association

Subject: Establishing and Achieving National Goals to Eliminate Lead Poisoning and Prevent Lead Exposures to Children

Referred to: Reference Committee K
(Paul A. Friedrichs, MD, Chair)

1 Whereas, Scientists agree there is no safe level of lead exposure for fetal or early childhood
2 development¹; and
3
4 Whereas, Lead exposure continues to be a preventable cause of intellectual impairment, ADHD,
5 learning disabilities and behavior disorders for millions of children; and
6
7 Whereas, Approximately half a million U.S. children ages 1-5 have blood lead levels greater
8 than 5 µg/dL (50 ppb); and
9
10 Whereas, Approximately 50 percent of U.S. children ages 1-5 have blood lead levels greater
11 than 1 µg/dL (10 ppb), based on blood lead distribution among children in the most recent
12 National Health and Nutrition Examination Survey (NHANES)²; and
13
14 Whereas, Adverse effects on brain development, cognition, attention and behavior have been
15 found at blood lead levels lower than 5 µg/dL (50 ppb)³; and
16
17 Whereas, Our country's current standards for allowable levels of lead in dust, soil, air and
18 drinking water are woefully outdated and fail to protect prenatal and children's health; and
19
20 Whereas, Children in communities of color and socioeconomically stressed communities are
21 more highly exposed to lead, and suffer disproportionate health effects⁴; and
22
23 Whereas, Studies have documented the potential for cumulative and synergistic health effects
24 from combined exposure to lead and social stressors⁵; and
25
26 Whereas, Health professionals, scientists, policymakers and advocates are gathering in
27 Washington, D.C., in December 2016 for a National Lead Summit to issue a call for action to
28 eliminate childhood lead poisoning; and

¹ Lanphear BP, Hornung R, Khoury J, Yolton K, Baghurst P, Bellinger DC, et al. 2005. Low-level environmental lead exposure and children's intellectual function: an international pooled analysis. *Environ Health Perspect* 113(7):894-899.

² Jain, RB. 2016. Trends and variability in blood lead concentrations among U.S. children and adolescents. *Environ Sci Pollut Res*. DOI 10.1007/s11356-016-6039-0

³ National Toxicology Program. 2012. Monograph on health effects of low-level lead. (1): xiii, xv=148.

⁴ Centers for Disease Control and Prevention. 2013. Blood lead levels in children aged 1-5 years – United States, 1999-2010. *Morbidity and Mortality Weekly Report*. 62(13); 245-248. <http://www.cdc.gov/MMWR/preview/mmwrhtml/mm6213a3.htm>

⁵ Cory-Slechta DA, Virgolini MB, Thiruchelvam M, Weston DD, Bauter MR. 2004. Maternal stress modulates the effects of developmental lead exposure. *Environ Health Perspect* 112(6):717-730.

1 Whereas, An alliance of scientists and health professionals, including physicians, collaborating
2 as “Project TENDR” (Targeting Environmental Neuro-Developmental Risks), published a
3 consensus statement in July, 2016, that reviewed the evidence on lead and
4 neurodevelopmental disorders, and concluded “taking further preventive action on lead is
5 imperative”⁶; and
6

7 Whereas, Project TENDR in 2016 issued recommendations to establish and achieve national
8 goals to 1) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021; and 2)
9 eliminate lead exposures to pregnant women and children so that by 2030, no child would have
10 a blood lead level > 1 µg/dL (10 ppb); therefore be it
11

12 RESOLVED, That our American Medical Association call on the United States government to
13 establish national goals to:

- 14 a) Ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and
- 15 b) Eliminate lead exposures to pregnant women and children, so that by 2030, no child would
16 have a blood lead level > 1 µg/dL (10 ppb)(New HOD Policy); and be it further
17

18 RESOLVED, That our AMA call on the United States government in all its agencies to pursue
19 the following strategies to achieve this goal:

- 20 a) Adopt health-based standards and action levels for lead that rely on the most up-to-date
21 scientific knowledge to prevent and reduce human exposure to lead, and assure prompt
22 implementation of the strongest available measures to protect pregnant women and
23 children from lead toxicity and neurodevelopmental impairment,
- 24 b) Identify and remediate current and potential new sources of lead exposure (in dust, air,
25 soil, water and consumer products) to protect children before they are exposed,
- 26 c) Continue targeted screening of children to identify those who already have elevated blood
27 lead levels for case management, as well as educational and other services,
- 28 d) Eliminate new sources of lead introduced or released into the environment, which may
29 entail banning or phasing out all remaining uses of lead in products (aviation gas,
30 cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and
31 the export of products containing lead, and setting more protective limits on emissions
32 from battery recyclers and other sources of lead emissions;
- 33 e) Provide a dedicated funding stream to enhance the resources available to identify and
34 eliminate sources of lead exposure, and provide educational, social and clinical services to
35 mitigate the harms of lead toxicity, particularly to protect and improve the lives of children
36 in communities that are disproportionately exposed to lead; and,
- 37 f) Establish an independent expert advisory committee to develop a long-term national
38 strategy, including recommendations for funding and implementation, to achieve the
39 national goal of eliminating lead toxicity in pregnant women and children, defined as blood
40 lead levels above 1 µg/dL (10 ppb). (Directive to Take Action)

Fiscal Note: Minimal – Less than \$1000.

Received: 11/8/16

⁶ Bennett D, Bellinger DC, Birnbaum, LA, et al. 2016. Project TENDR: targeting environmental neuro-developmental risks. The TENDR consensus statement. Environ Health Perspect 124(7). DOI:10.1289/EHP358

RELEVANT AMA POLICY**Reducing Lead Poisoning H-60.924**

Our AMA: (1) supports regulations and policies designed to protect young children from exposure to lead; (2) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (3) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (4) promotes community awareness of the hazard of lead-based paints; and (5) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

CCB/CLRPD Rep. 3, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 927
(I-16)

Introduced by: Resident and Fellow Section
Subject: The DEA Order to Reduce Opioid Production
Referred to: Reference Committee K
(Paul A. Friedrichs, MD, Chair)

1 Whereas, On October 4th, 2016, the Drug Enforcement Agency (DEA) ordered a reduction in
2 the amount of almost every Schedule II opioid medication that may be manufactured in the
3 United States in 2017 by 25 percent or more;¹ and
4
5 Whereas, Opioids such as hydrocodone will be reduced by one third to 66% of last year's level;
6 and
7
8 Whereas, There was no public comment period nor release of the underlying data leading to the
9 DEA's decision; and
10
11 Whereas, Prescriptions written for opioids by DEA-registered practitioners has decreased
12 according to sales data obtained by the DEA from IMS Health; and
13
14 Whereas, The Aggregate Production Quota (APQ) is the total amount of a controlled substance
15 necessary to meet the estimated medical, scientific, research, industrial, and export needs for
16 the year and for the maintenance of reserve stocks; and
17
18 Whereas, The DEA claims the reduction in manufacturing is to eliminate the 25 percent buffer
19 that was added to the APQ annually in 2013 through 2016 to guard against shortages; and
20
21 Whereas, The Controlled Substances Act (CSA) established a quota system intended to reduce
22 or eliminate diversion from "legitimate channels of trade" by controlling "the quantities of the
23 basic ingredients needed for the manufacture of [controlled substances]" and limit the amounts
24 available to prevent diversion; and
25
26 Whereas, In 2011, attempts to curb "pill mill" activity in Florida led to decreased prescription-
27 drug overdoses within the first year but a 39% increase in heroin deaths, as people cut off from
28 their legal pain medication turned to an illegal drug;² and
29
30 Whereas, Reduced production of narcotics may seem like an easy solution to the nations
31 narcotic epidemic, there may be numerous unintended consequences which can be detrimental
32 to our health care system; and
33
34 Whereas, Reduced production of narcotics can potentially increase barriers to access for
35 patients by both increased costs and lack of pharmacies that dispense these drugs ultimately at
36 the detriment of the patients (as evident with numerous drug shortages over the past few years
37 (epipen, neostigmine, propofol); and

1 Whereas, Insurance companies have already begun to reduce their coverage of narcotic
2 prescriptions and price increases associated with production decreases may make insurance
3 companies more likely to further reduce coverage; and
4

5 Whereas, Patients with chronic pain treated with opioids frequently suffer from ancillary mental
6 health problems--including depression, anxiety and insomnia--and are at least twice as likely to
7 commit suicide;³ and
8

9 Whereas, Restriction of access to opioids to chronic pain patients may actually lead to more
10 overdoses and suicides; and
11

12 Whereas, While, patients who are being treated for pain with chronic opioid therapy often become
13 physically dependent on their prescribed opioid analgesics, only a small percentage of these
14 patients develop opioid use disorder (Only around 1.5% experience abuse, addiction, or aberrant
15 drug related behavior if they have no history of substance abuse (Fishbain et al., 2008)); and
16

17 Whereas, The DEA has never profoundly ordered such a large cut of opioid production; and
18

19 Whereas, It is unknown what effect production cuts will have on public health, drug costs,
20 patient access and a plethora of other consequences; therefore be it
21

22 RESOLVED, That our American Medical Association encourage relevant stakeholders to
23 research the overall effects of opioid production cuts (New HOD Policy); and be it further
24

25 RESOLVED, That our AMA encourage the DEA to postpone any opioid production cuts until the
26 potential effects of production quotas are better elucidated (New HOD Policy); and be it further
27

28 RESOLVED, That our AMA encourage the DEA to be more transparent when developing
29 medication production guidelines. (New HOD Policy)

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

Received: 11/12/16

References:

¹ www.dea.gov/divisions/hq/2016/hq100416.shtml

² www.thedailybeast.com/articles/2016/04/15/feds-pill-crackdown-drives-pain-patients-to-heroin.html

³ <https://www.ncbi.nlm.nih.gov/pubmed/16420727>

RELEVANT AMA POLICY

Drug Abuse Related to Prescribing Practices H-95.990

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:

A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.

B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:

A. promotes physician training and competence on the proper use of controlled substances;

B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;

C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and

D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.

4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 907, I-11; Appended: Res. 219, A-12; Reaffirmation A-15; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15)

Cost of Prescription Drugs H-110.996

Our AMA supports increasing physician awareness about the cost of drugs prescribed for their patients. (Res. 173, A-91; Reaffirmed: Res. 520, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09)

National Drug Shortages H-100.956

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

2. Our AMA supports authorizing the Secretary of Health and Human Services to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

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

4. The Council on Science and Public Health shall continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

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

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

7. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

8. Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs. (CSAPH Rep. 2, I-11; Modified: CSAPH Rep., A-12; Modified: CSAPH Rep. 2, I-12; Modified: CSAPH Rep. 8, A-13; Modified in lieu of Res. 912, I-13; Modified: CSAPH Rep. 3, A-14; Modified: CSAPH Rep. 2, I-15)

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 928
(I-16)

Introduced by: Organized Medical Staff Section
Subject: Closing the Loop on Pharmaceuticals
Referred to: Reference Committee K
(Paul A. Friedrichs, MD, Chair)

- 1 Whereas, There has been little to no organized public education on the safe and proper
2 disposal of drugs, pills, and other pharmaceuticals; and
3
4 Whereas, The American Medical Association (AMA) can take a leadership role in addressing
5 the growing and negative environmental impact on the nation's water systems of improper
6 disposal of these drugs and their metabolites; and
7
8 Whereas, There have been reports in the media on drugs and their metabolites turning up in
9 major waste-water systems and in downstream effluent pools, such as cocaine in the fish of
10 Puget Sound, and hormones or their metabolites being found in fish and other amphibians;
11 therefore be it
12
13 RESOLVED, That our American Medical Association take a leadership role in working with
14 large, national chains and corporate conglomerates that dispense pharmaceutical drugs to
15 address the growing and negative environmental impact caused by the improper disposal of
16 these pharmaceutical drugs and their metabolites (Directive to Take Action); and be it further
17
18 RESOLVED, That our AMA urge federal agencies to mandate pharmaceutical companies and
19 retailers to take on the responsibility of taking back and properly disposing of outdated, expired,
20 or unused drugs in an environmentally responsible and proper way (Directive to Take Action);
21 and be it further
22
23 RESOLVED, That our AMA educate the public on the growing hazards and necessary methods
24 to deal with the threat to our water systems posed by the improper disposal of pharmaceutical
25 drugs and their metabolites. (Directive to Take Action)

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

Received: 11/12/2016

RELEVANT AMA POLICY

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)

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)

Not for consideration

Resolutions not for consideration

601 Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations

605* Study of Models of Childcare Provided at Healthcare Institutions

821# Support the ONE KEY QUESTION Initiative to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies

* contained in Handbook Addendum

contained in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 821
(I-16)

Introduced by: Oregon

Subject: Support the ONE KEY QUESTION® Initiative to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

1 Whereas, Almost half (51%) of all pregnancies in the United States are unintended, which has
2 significant physical and socio-economic consequences for women and their families, with a real
3 cost in lives and public health; and
4

5 Whereas, Rates of unintended pregnancies disproportionately impact women of color, women in
6 poverty, and women with less education; and
7

8 Whereas, Women with unintended pregnancies are unlikely to have taken folic acid before
9 conceiving and are less likely to receive early prenatal care, thus increasing the risk of babies
10 born with health challenges; and
11

12 Whereas, Women need comprehensive information, services and referrals in order to have
13 optimal health, healthy pregnancies, and the best possible birth outcomes; and
14

15 Whereas, ONE KEY QUESTION® is an initiative advocating that health care providers ask
16 women at risk of pregnancy, "Would you like to become pregnant in the next year?" as a routine
17 assessment question. Asking this question gives women the opportunity to engage in
18 conversations about their preventive reproductive health care that can result in the uptake of
19 evidence-based contraception and preconception care; and
20

21 Whereas, ONE KEY QUESTION® (OKQ) includes four patient response categories (Yes,
22 Unsure, Ok Either Way, No) to ensure the patient's goals for if and when to become pregnant
23 are centered in health care decision making; and
24

25 Whereas, Providers want to use OKQ as a routine and proactive intervention to address
26 pregnancy intention with patients and have requested a consistent and efficient way to
27 document care in their Electronic Health Records; and therefore be it
28

29 RESOLVED, That our American Medical Association support the use of ONE KEY
30 QUESTION® (OKQ) as part of routine well care and recommend it be built in EHRs so that
31 providers can document OKQ screening and services provided based on a woman's response.
32 (New HOD Policy)

Fiscal Note: Minimal – less than \$500.

Received: 10/28/16

References:

Committee on Health Care for Underserved Women, " Committee Opinion: Reproductive Life Planning to Reduce Unintended Pregnancy," *The American College of Obstetricians and Gynecologists* Number 654 (February 2016): 1. <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co654.pdf?dmc=1&ts=20160131T1016396951>

Informational Reports

BOT Report(s)

- 01 2016 AMA Advocacy Efforts
- 04 Redefining the AMA's Position on the ACA and Healthcare Reform - Update
- 10 AMA Initiatives on Pharmaceutical Costs
- 11 2017 Strategic Plan

CEJA Opinion(s)

- 01 Modernized Code of Medical Ethics
- 02 Ethical Practice in Telemedicine

CEJA Report(s)

- 03 CEJA and House of Delegates Collaboration
- 04 Ethical Physician Conduct in the Media

CSAPH Report(s)

- 02 National Drug Shortages: Update

* contained in Handbook Addendum

contained in Sunday Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Angus M. McBryde, MD

Introduced by the AMA Senior Physicians Section

Whereas, The untimely death of our Senior Physicians Section Chair-Elect profoundly shocked those of us who had come to know him; and

Whereas, Dr. Angus M. McBryde had exemplified uncommon personal and professional acumen in the many accomplishments that he demonstrated over the years: Collegiate track/ Cross Country star with ultimate induction into the Davidson College Sports Hall of Fame; Senior Class President of his Duke Medical School; National Vice-President of the Student American Medical Association; U.S. Naval medical officer; residency in orthopedics at Duke Medical School; Alabama Sports Person of The Year; Chair of Department of Orthopedic Surgery at the University of South Carolina, and subsequently at the University of South Alabama; team doctor at various times for the South Carolina Gamecocks, the University of Alabama and Auburn University; Distinguished Southern Orthopedist; Distinguished Alumnus of Duke Medical School; team physician for the 1987 World Games in Yugoslavia, and for the U.S. National teams at the Seoul and Atlanta summer Olympics; and author of over seventy scholarly publications; and

Whereas, Dr. Angus McBryde had recently become Chair-Elect of our AMA Senior Physicians Section Governing Council; and

Whereas, Angus McBryde's many accomplishments were second only to his warm personality and friendly manner; and

Whereas, Our Senior Physicians Section will sorely miss his contributions and leadership; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize and commend his life of service to all who knew him; and be it further

RESOLVED, That a copy of this commendation be presented his widow, Kay.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Walter A. Reiling Jr., MD, FACS

Introduced by Ohio

Whereas, Walter A. Reiling, Jr., MD, FACS, passed away on October 25, 2016; and

Whereas, Dr. Reiling practiced medicine for fifty plus years after attending Harvard University Medical School and completing his surgical training at the Harvard surgical service at Boston City Hospital; and during those five decades he provided exemplary care to his patients and served in every leadership position in the Montgomery County Medical Society and the Ohio State Medical Association; and

Whereas, Dr. Reiling joined the OSMA Delegation to the AMA in 1987 and was elected delegate in 1993; he was ultimately elected chair of the OSMA Delegation, chaired the six state Great Lakes Coalition of the AMA HOD and he also served as a founding member of the OSMA and the AMA Organized Medical Staff Section serving on their boards and as Chair of both entities; and

Whereas, He was appointed by the Ohio governor as a member of the Ohio Board of Regents, the controlling authority of college and graduate education resources in Ohio, there he was a critical leader in the Board's investigation of trends in the health care provider workforce in Ohio; and

Whereas, Dr. Reiling was a critical thought leader who helped the OSMA confront multiple issues of health care delivery reform, including serving as chair of the OSMA Task Force on Health System Reform. His task force produced a breakthrough plan to increase physician involvement and patient responsibility in the delivery of alternative health care delivery systems; and

Whereas, The OSMA presented Walter A. Reiling Jr. MD, FACS with the OSMA Distinguished Service Citation in April 2016, with the heartfelt thanks for his decades of leadership; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Dr. Reiling for outstanding service to the profession of medicine and his patients; and be it further

RESOLVED, That our AMA House of Delegates extend its deepest sympathy to the family members of Walter A. Reiling, Jr., MD, FACS.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Chad Anthony Rubin, MD, FACS

**Introduced by
American College of Surgeons and
American Society of Plastic Surgeons**

Whereas, Dr. Chad A. Rubin, MD, FACS, a Columbia, South Carolina general surgeon, passed away on July 3, 2016; and

Whereas, Dr. Rubin graduated from Southern Illinois Medical School, Springfield, IL; completed a surgical residency at Wake Forest Baptist Medical Center in Winston-Salem, North Carolina; and practiced surgery in Columbia, South Carolina, most recently at Providence Hospital; and

Whereas, Earlier this year, Providence Hospital inducted him into the prestigious Society of Saint Luke, recognizing him for his distinguished service; and

Whereas, During his extensive surgical career, he treasured his professional relationships with his physician colleagues, serving in leadership roles with the American College of Surgeons (long-time Member and Chair, General Surgery Coding and Reimbursement Committee; Governor, ACS Board of Governors; Member, Health Policy and Advocacy Group; Member, ACS SurgeonsPAC; Chair, Committee on Young Surgeons; and Delegate to the AMA Young Physicians Section and AMA House of Delegates); as well as the South Carolina Chapter of the ACS; and

Whereas, Dr. Rubin was highly respected and beloved as a compassionate surgeon and friend who demonstrated through his actions that his responsibility is to patients first; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Doctor Chad A. Rubin for outstanding service to the profession of surgery and his patients; and be it further

RESOLVED, That our AMA House of Delegates extend its deepest sympathy to the family members of Chad A. Rubin, MD, FACS.