Abridged Handbook Document is currently laid out for letter-sized paper; change as desired.

Note: this table includes only the recommendations from reports and the resolve statements from resolutions. The table can be sorted in Word using either the “committee” column or the “item” column (or both). Alternatively, the table can be copied to a spreadsheet and manipulated there. The table includes all items of business contained in the initial Handbook excepting informational and sunset reports. Only the primary sponsor, usually the submitter, is listed for resolutions

| **Cmte\*** | **Item** | **Sponsor**† | **Title / Recommendations or Resolves** |
| --- | --- | --- | --- |
| .Con | BOT 14 | n/a | Protection of Physician Freedom of Speech  The Board of Trustees recommends that the following be adopted in lieu of Resolution 5-I-17 and the remainder of this report be filed:  1. That our American Medical Association strongly oppose litigation challenging the exercise of a physician’s First Amendment right to express opinions regarding medical issues; and  2. That AMA Policy H-460.895, “Free Speech Applies to Scientific Knowledge,” be reaffirmed (Reaffirm HOD Policy) |
| .Con | CEJA 01 | n/a | Competence, Self-Assessment and Self-Awareness  The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:  The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.  However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.  To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:   1. Cultivate continuous self-awareness and self-observation.   (b) Recognize that different points of transition in professional life can make different demands on competence.  (c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.  (d) Seek feedback from peers and others.  (e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest.  (f) Intervene in a timely and appropriate manner when a colleague’s ability to practice safely is compromised by impairment, in keeping with ethics guidance.  Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment. |
| .Con | CEJA 02 | n/a | Study Aid-in-Dying as End-of-Life Option / The Need to Distinguish “Physician-Assisted Suicide” and “Aid in Dying”  The Council on Ethical and Judicial Affairs has reviewed the literature and received thoughtful input from numerous individuals and organizations to inform its deliberations, and is deeply grateful to all who shared their insights. CEJA engaged in extensive, often passionate discussion about how to interpret the *Code of Medical Ethics* in light of ongoing debate and the irreducible differences in moral perspectives identified above. The council recognized that supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity, but diverge in drawing different moral conclusions from those underlying values in equally good faith. The council further recognized that medicine must learn from experience of physician-assisted suicide, and must ensure that, where the practice is legal, safeguards are improved.  After careful consideration, CEJA concludes that in existing opinions on physician-assisted suicide and the exercise of conscience, the *Code* offers guidance to support physicians and the patients they serve in making well-considered, mutually respectful decisions about legally available options for care at the end of life in the intimacy of a patient-physician relationship.  The Council on Ethical and Judicial Affairs therefore recommends that the *Code of Medical Ethics* not be amended, that Resolutions 15-A-16 and 14-A-17 not be adopted and that the remainder of the report be filed. |
| .Con | CEJA 03 | n/a | Amendment to E-2.2.1, “Pediatric Decision Making”  In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Opinion E-2.2.1, “Pediatric Decision Making,” be amended by substitution as follows in lieu of Resolutions 3-A-16, “Supporting Autonomy for Patients with Differences of Sex Development (DSD),”and 13-A-18, “Opposing Surgical Sex Assignment of Infants with Differences of Sex Development,” and the remainder of this report be filed:  As the persons best positioned to understand their child’s unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children’s capacity to become independent decision makers. In giving or withholding permission for medical treatment for their children, parents/guardians are expected to safeguard their children’s physical health and well-being and to nurture their children’s developing personhood and autonomy.  But parents’ authority as decision makers does not mean children should have no role in the decision-making process. Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek minor patients’ assent to treatment. Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and parents/guardians should respect a child’s refusal to assent, and when circumstances permit should explore the child’s reason for dissent.  For health care decisions involving minor patients, physicians should:  (a) Provide compassionate, humane care to all pediatric patients.  (b) Negotiate with parents/guardians a shared understanding of the patient’s medical and psychosocial needs and interests in the context of family relationships and resources.  (c) Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.  (d) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.  (e) Provide a supportive environment and encourage parents/guardians to discuss the child’s health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with similar decisions and have volunteered their support as peers.  (f) When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in decision making in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.  (g) When it is not clear whether a specific intervention promotes the patient’s interests, respect the decision of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.  (h) When there is ongoing disagreement about patient’s best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource. |
| .Con | CEJA 04 | n/a | CEJA Role in Implementing H-140.837, “Anti-Harassment Policy”  The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:  1. That provision (3) of H-140.837, “Anti-Harassment Policy” be rescinded (Directive to Take Action); and  2. That the process for implementing AMA’s anti-harassment policy be referred to the Board of Trustees for further study (Directive to Take Action) |
| .Con | CEJA 05 | n/a | Physicians’ Freedom of Speech  For the foregoing reasons, the Council on Ethical and Judicial Affairs recommends that Resolution 6-I-17, “Physicians’ Freedom of Speech,” not be adopted and the remainder of this report be filed. |
| .Con | Res 001 | Wisconsin | Support of a National Registry for Advance Directives  RESOLVED, That our American Medical Association advocate for the establishment and maintenance of a national, no-charge, confidential and secure method for the storage and retrieval of advance directive documents by authorized agents. |
| .Con | Res 002 | GLMA | Protecting the Integrity of Public Health Data Collection  RESOLVED, That our American Medical Association advocate for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey of Older Americans Act Participants, all-payer claims databases; and be it further  RESOLVED, That our AMA advocate against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data. |
| .Con | Res 003 | Indiana | Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children  RESOLVED, That our American Medical Association officially object to policies separating undocumented immigrant parents and/or guardians from children, as well as allowing unaccompanied undocumented minors access to the U.S.; and be it further  RESOLVED, That our AMA condemn the practice of administering psychotropic drugs to immigrant children without parental or guardian consent or court order except in the case of imminent danger to self or others; and be it further  RESOLVED, That our AMA support a position whereby federal immigration officials would become more aware of the emotional decompensation in this immigrant population, with the establishment of policies designed to decrease stress and emotional trauma. |
| B | BOT 04 | n/a | Increased Use of Body-Worn Cameras by Law Enforcement Officers  The Board recommends that the following be adopted in lieu of Resolution 208-I-17, and that the remainder of the report be filed.  That our American Medical Association work with interested state and national medical specialty societies to support state legislation and/or regulation that would encourage the use of body-worn camera programs for law enforcement officers and fund the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies. |
| B | BOT 05 | n/a | Exclusive State Control of Methadone Clinics  The Board recommends that the following recommendation be adopted in lieu of Resolution 211-I-17, and that the remainder of the report be filed.  1. That our American Medical Association (AMA) support the right of federally certified Opioid Treatment Programs (OTPs) to be located within residential, commercial and any other areas where there is a demonstrated medical need;  2. That our AMA encourage state governments to collaborate with health insurance companies and other payers, state medical societies, national medical specialty societies, OTPs and other health care organizations to develop and disseminate resources that identify where OTP providers operate in a state and take part in surveillance efforts to obtain timely and comprehensive data to inform treatment opportunities; and  3. That our AMA advocate for the federal agencies responsible for approving opioid treatment programs to consider the views of state and local stakeholders when making decisions about OTP locations and policies. |
| B | BOT 07 | n/a | Advocacy for Seamless Interface Between Physicians Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs)  The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 212-A-17, and the remainder of the report be filed:  1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying whether PDMPs can distinguish team-based care from uncoordinated care, misuse, or “doctor shopping,” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care.  2. That our AMA urge EHR vendors to increase transparency of custom connections and costs for physicians to integrate their products in their practice.  3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. |
| B | BOT 08 | n/a | 340B Drug Discount Program  In light of these considerations, your Board of Trustees recommends that the following recommendations be adopted in lieu of the third resolve Resolution 225-A-18 and the remainder of this report be filed:  1. That our American Medical Association support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices.  2. Our AMA will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program. |
| B | BOT 11 | n/a | Violence Prevention  The Board of Trustees recommends that the following recommendations be adopted in lieu of the first and third resolves of Resolution 419-A-18 and the remainder of the report be filed.  1. That Policy H-145.996, “Firearm Availability” be amended by addition and deletion to read as follows:  H-145.996 Firearm Availability  1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.  2. Our AMA ~~policy is to~~ supports requiring ~~require~~ the licensing/permitting of ~~owners of~~ firearm~~s~~ owners and purchasers, including the completion of a required safety course, and registration of all firearms.  3. Our AMA supports granting local law enforcement discretion over whether to issue concealed carry permits. ~~in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding “concealed carry”,~~ ~~by supporting “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and by supporting “red-flag” laws for individuals who have demonstrated significant signs of potential violence.~~ In supporting local law enforcement, we also support ~~as well~~ the importance of ~~“~~due process~~”~~ so that ~~decisions could be reversible by~~ individuals can petition ~~petitioning in court~~ for their rights to be restored.  2. That Policy H-145.972, “Firearms and High-Risk Individuals” be reaffirmed.  Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.  3. That our American Medical Association: (1) encourages the enactment of state laws requiring the reporting of relevant mental health records, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of mental health records to NICS to improve the quality and timeliness of the data. |
| B | Res 201 | Virginia | Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application  RESOLVED, That our American Medical Association develop model state legislation for physicians being credentialed by a health plan to treat patients and retroactively receive payments if they are ultimately credentialed. |
| B | Res 202 | Pennsyl­vania | Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings  RESOLVED, That our American Medical Association identify and work to remove those administrative and/or legal barriers that hamper the ability of primary care providers to prescribe methadone, through all appropriate legislative and/or regulatory means possible; and be it further  RESOLVED, That our AMA, working with other federation stakeholders, identify the appropriate educational tools that would support primary care physicians to provide ongoing methadone treatment for appropriate patients. |
| B | Res 203 | RFS | Support for the Development and Distribution of HIPAA-Compliant Communication Technologies  RESOLVED, That our American Medical Association promote the development and use of Health Insurance Portability and Accountability Act of 1996 (HIPAA) -compliant technologies for text messaging, electronic mail and video conferencing. |
| B | Res 204 | RFS | Restriction on IMG Moonlighting  RESOLVED, That our American Medical Association advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight. |
| B | Res 205 | IMG | Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)  RESOLVED, That our American Medical Association support legalization of the Deferred Action for Legal Childhood Arrival (DALCA); and be it further  RESOLVED, That our AMA work with the appropriate agencies to allow DALCA children to start and finish medical school and/or residency training until these DALCA children have officially become legal. |
| B | Res 206 | Florida | Repealing Potential Penalties Associated with MIPS  RESOLVED, That our American Medical Association advocate to repeal all potential penalties associated with the MIPS program. |
| B | Res 207 | MSS | Defense of Affirmative Action  RESOLVED, That our American Medical Association oppose legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population. |
| B | Res 208 | Nebraska | Increasing Access to Broadband Internet to Reduce Health Disparities  RESOLVED, That our American Medical Association advocate for the expansion of broadband connectivity to all rural areas of the United States. |
| B | Res 209 | WPS | Sexual Assault Education and Prevention in Public Schools  RESOLVED, That our American Medical Association support state legislation mandating that public middle and high school health education programs include age appropriate information on sexual assault education and prevention, including but not limited to topics of consent and sexual bullying. |
| B | Res 210 | District of Columbia | Forced Organ Harvesting for Transplantation  RESOLVED, That our American Medical Association reaffirm Ethical Opinion E-6.1.1, “Transplantation of Organs from Living Donors,”, and believes that transplant surgeons, especially those who come to the United States for training in transplant surgery, must agree to these guidelines, and that American medical and hospital institutions not be complicit in any ethical violations or conflicts of interest; and be it further  RESOLVED, That our AMA representatives to the World Medical Association request an independent, interdisciplinary (not restricted to transplant surgeons), transparent investigation into the Chinese practices of organ transplantation including (but not limited to): the source of the organs as well as the guidelines followed; and to report back on these issues as well as the status of Prisoners of Conscience as sources of transplantable organs; and be it further  RESOLVED, That our AMA call upon the U.S. Government to protect the large number of transplant tourists by implementing legislation to regulate the evolving, ethical challenges by initiating a Reciprocal Transplant Transparency Act which would blacklist countries that do not meet the same transparency and ethical standards practiced in the U.S. (such as the public listing of annual transplant numbers by every transplant center to permit scrutiny). |
| B | Res 211 | HRS | Eliminating Barriers to Automated External Defibrillator Use  RESOLVED, That our American Medical Association update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications; and be it further  RESOLVED That our AMA urge AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and be it further  RESOLVED That our AMA support consistent and uniform legislation across states for the legal protection of untrained personnel who use AEDs in the course of attempting to aid a sudden cardiac arrest victim. |
| B | Res 212 | MSS | Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings  RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents. |
| B | Res 213 | MSS | Increasing Firearm Safety to Prevent Accidental Child Deaths  RESOLVED, That our American Medical Association advocate for enactment of Child Access Prevention laws in all 50 states or as federal law. |
| B | Res 214 | Wisconsin | A Public Health Case for Firearm Regulation  RESOLVED, That our American Medical Association support a public health approach to evidence-based firearm laws and regulations that do not conflict with the Second Amendment to the U.S. Constitution; and be it further  RESOLVED, That our AMA oppose barriers to firearm safety. |
| B | Res 215 | AAP | Extending the Medical Home to Meet Families Wherever They Go  RESOLVED, That our American Medical Association develop model legislation to permit primary care physicians, who work in medical homes/primary care practices that satisfy the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition Program guidelines, and who have documented a face-to-face patient-care relationship, to provide telehealth services for the patient when the patient travels to any of the fifty states. |
| B | Res 216 | ASCO | Medicare Part B Competitive Acquisition Program (CAP)  RESOLVED, That our American Medical Association advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:  (1) it must be genuinely voluntary and not penalize practices which choose not to participate;  (2) it should provide supplemental payments to support complex care coordination and management for cancer patients, including reimbursement for costs associated with the administration of anticancer drugs such as special handling and storage for hazardous drugs; (3) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;  (4) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;  (5) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician; and  (6) it should not be tied to negotiated discounts such as rebates to pharmacy benefit managers given in exchange for implementing utilization management policies like step therapy. |
| B | Res 217 | ASCO | Opposition to Medicare Part B to Part D Changes  RESOLVED, That our American Medical Association advocate against Medicare changes which would recategorize Medicare Part B drugs into Part D. |
| B | Res 218 | Colorado | Alternatives to Tort for Medical Liability  RESOLVED, That our American Medical Association review options for alternatives to the tort system that will assure fair compensation to individuals harmed in the process of receiving medical care and separately identify and hold accountable physicians and other practitioners for dangerous or unacceptable practice as well as identify opportunities for improving systems to maximize the safety of medical care (as in New Zealand and other countries); and be it further  RESOLVED, That our AMA develop new policy which can be used for advocacy or development of model state legislation to replace the current tort system. |
| B | Res 219 | Indiana | Promotion and Education of Breastfeeding  RESOLVED, That our American Medical Association encourage the federal government to legislate appropriate disclosures of the health benefits or limitations of synthetic infant formulas, develop a breast feeding awareness education program, ensure that our representatives to global meetings comport themselves in an unbiased manner that better represents a compromise of all views of this particular issue and promote development of an affordable and more equivalent substitute for breast milk for women who absolutely are unable to nurse; and be it further  RESOLVED, That our AMA and all state medical associations support legislation for workplace accommodation for nursing mothers in those states that do not already have such laws. |
| B | Res 220 | Indiana | Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement  RESOLVED, That our American Medical Association support legislation and federal funding for evidence-based training programs aimed at educating corrections officers in effectively interacting with mentally ill populations in federal prisons. |
| B | Res 221 | Kentucky | Regulatory Relief from Burdensome CMS "HPI" EHR Requirements  RESOLVED, That our American Medical Association advocate for regulatory relief from the burdensome Centers for Medicare and Medicaid Services (CMS) History of Present Illness (HPI) requirements arbitrarily equating “keystroking” in an electronic health record (EHR) with validation of the fact that a face to face encounter has been performed by the physician/NPP; and be it further  RESOLVED, That our AMA advocate for the acceptance of the physician's electronic signature as substantiation and verification that the HPI was reviewed and appropriate additional information was obtained and recorded whomever "keystroked" this information. |
| B | Res 222 | Maryland | Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS  RESOLVED, That our American Medical Association work to establish regulation and/or legislation requiring that all quality measure data be collected in summary format only with no personally identified information included. |
| B | Res 223 | Michigan | Permanent Reauthorization of the State Children’s Health Insurance Program  RESOLVED, That our American Medical Association amend policy H-290.971, “Expanding Enrollment for the State Children's Health Insurance Program (SCHIP),” by addition and deletion to read as follows:  Our AMA continues to support:  a. health insurance coverage of all children as a strategic priority;  b. efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms;  c. the permanent reauthorization of SCHIP ~~in 2007~~; and  d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for SCHIP eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage; and be it further  RESOLVED, That our American Medical Association amend policy D-290.982, “State Children's Health Insurance Program Reauthorization (SCHIP),” by addition and deletion to read as follows:  1. Our AMA strongly supports the permanent reauthorization of the State Children's Health Insurance Program ~~reauthorization~~ and will lobby toward this end.  2. Our AMA will lobby Congress to:  a. provide performance-based financial assistance for new coverage costs with expanded coverage of uninsured children through SCHIP through an enhanced federal match;  b. allow states to use SCHIP funds to augment employer-based coverage;  c. allow states to explicitly use SCHIP funding to cover eligible pregnant women;  d. allow states the flexibility to cover all eligible children residing in the United States and pregnant women through the SCHIP program without a mandatory waiting period;  e. provide $60 billion in additional funding for SCHIP to ensure adequate funding of the SCHIP program and incentivize states to expand coverage to qualified children, and support incentives for physicians to participate; and  f. ensure predictable funding of SCHIP in the future.  3. Our AMA will urge Congress to provide targeted funding for SCHIP enrollment outreach; and be it further  RESOLVED, That our AMA actively lobby the United States Congress for a permanent reauthorization of the Children’s Health Insurance Program. |
| B | Res 224 | New York | Fairness in the Centers for Medicare & Medicaid Services Authorized Quality Improvement Organization’s (QIO) Medical Care Review Process  RESOLVED, That our American Medical Association seek by regulation and/or legislation to amend the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict; and be it further  RESOLVED, That our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise; and be it further  RESOLVED, That our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed. |
| B | Res 225 | New York | “Surprise” Out of Network Bills  RESOLVED, That our American Medical Association advocate that any federal legislation on “surprise” out of network medical bills be consistent with AMA Policy H-285.904, “Out-of-Network Care,” and apply to ERISA plans not subject to state regulation; and be it further  RESOLVED, That our AMA advocate that such federal legislation protect state laws that do not limit surprise out of network medical bills to a percentage of Medicare or health insurance fee schedules. |
| B | Res 226 | Utah | Support for Interoperability of Clinical Data  RESOLVED, That our American Medical Association review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. |
| B | Res 227 | ACRh | CMS Proposal to Consolidate Evaluation and Management Services  RESOLVED, That our American Medical Association actively seek and support congressional action before January 1, 2019 that would prevent implementation of changes to consolidate evaluation and management services as put forward in the CY 2019 Medicare physician fee schedule proposed rule if CMS in the final rule moves forward with the consolidation of evaluation and management services. |
| C | CME 01 | n/a | Competency of Senior Physicians  The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed.  1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles:  a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician’s competency can be highly variable, and wide variations are seen in cognitive performance with aging.  b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues’ competency.  c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians’ ability to perform the tasks specifically required in their practice environment.  d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.  e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians’ practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.  f) Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.  g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.  h) Cost conscious: Procedures and screening mechanisms that are distinctly different from “for cause” assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems.  2. That our AMA encourage the Federation of State Medical Boards, Council of Medical Specialty Societies, and other interested organizations to develop educational materials on the effects of age on physician practice for senior/late career physicians. 3. That Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” be rescinded, as having been fulfilled by this report. |
| C | CME 03 | n/a | Developing Physician-Led Public Health/Population Health Capacity in Rural Communities  The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of the report be filed:   1. That Policy D-295.311, “Developing Physician Led Public Health / Population Health Capacity in Rural Communities,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy) 2. That our American Medical Association (AMA) reaffirm the following policies:  D-295.327, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum” D-305.964, “Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion” D-305.974, “Funding for Preventive Medicine Residencies” H-425.982, “Training in the Principles of Population-Based Medicine” D-440.951, “One-Year Public Health Training Options for all Specialties” H-440.954, “Revitalization of Local Public Health Units for the Nation” H-440.888, “Public Health Leadership” H-440.969, “Meeting Public Health Care Needs Through Health Professions Education” (Reaffirm HOD Policy) 3. That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially to women and those who are underrepresented in medicine. (Directive to Take Action) 4. That our AMA encourage public health leadership programs to evaluate the effectiveness of various leadership interventions. (Directive to Take Action) |
| C | CME 04 | n/a | Reconciliation of AMA Policy on Primary Care Workforce  The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed:   1. That our American Medical Association (AMA) adopt as policy “Principles of and Actions to Address Primary Care Workforce” the language shown in column 1 in Appendix A to this report. (New HOD Policy) 2. That our AMA rescind the following policies, as shown in Appendix C: 3. D-200.979, “Barriers to Primary Care as a Medical School Choice” 4. D-200.994, “Appropriations for Increasing Number of Primary Care Physicians” 5. H-200.956, “Appropriations for Increasing Number of Primary Care Physicians” 6. H-200.966, “Federal Financial Incentives and Medical Student Career Choice” 7. H-200.973, “Increasing the Availability of Primary Care Physicians” 8. H-200.975, “Availability, Distribution and Need for Family Physicians” 9. H-200.977, “Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians” 10. H-200.978, “Loan Repayment Programs for Primary Care Careers” 11. H-200.982, “Significant Problem of Access to Health Care in Rural and Urban Underserved Areas” 12. H-200.997, “Primary Care” 13. H-295.956, “Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers” 14. H-300.957, “Promoting Primary Care Services Through Continuing Medical Education” 15. H-310.973, “Primary Care Residencies in Community Hospitals” (Rescind HOD Policy) 16. That H-200.972, “Primary Care Physicians in the Inner City,” be amended by addition and deletion, and a title change, to read as follows:   “Primary Care Physicians in Underserved Areas”  Our AMA should pursue the following plan to improve the recruitment and retention of physicians in ~~the inner city~~ underserved areas:  (1) Encourage the creation and pilot-testing of school-based, ~~church~~ faith-based, and community-based urban/rural ~~“~~family ~~H~~health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.  (2) Encourage the affiliation of these family health clinics with ~~urban~~ local medical schools and teaching hospitals.  ~~(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts.~~  ~~(4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams.~~  (~~5~~3) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.  ~~(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies.~~  ~~(7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently.~~  (~~8~~4) Encourage the AMA Senior Physicians ~~Services Group~~ Section to consider the ~~use~~ involvement of retired physicians in underserved ~~urban~~ settings ~~of retired physicians~~, with appropriate mechanisms to ensure their competence.  (~~9~~5) Urge ~~urban~~ hospitals and medical societies to develop opportunities for physicians to work part-time to staff ~~urban~~ health clinics that help meet the needs of underserved patient populations.  (~~10~~6) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who ~~serve the inner-city poor~~ help meet the needs of underserved patient populations.  ~~(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination.~~  ~~(12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school.~~  ~~(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.~~  ~~(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.~~  (~~15~~7) Urge ~~urban~~ hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to ~~fill gaps in urban care~~ help meet the needs of underserved patient populations.  ~~(16) Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings.~~  ~~(17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.~~  ~~(18) Continue to urge measures to enhance payment for primary care in the inner city.~~ (Modify Current HOD Policy) |
| C | CME 05 | n/a | Reconciliation of AMA Policy on Medical Student Debt  The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed:   1. That our American Medical Association (AMA) adopt as policy “Principles of and Actions to Address Medical Education Costs and Student Debt” the language shown in column 1 of Appendix A of this report. (New HOD Policy) 2. That our AMA rescind the following policies, as shown in Appendix C: 3. D-305.956, “AMA Participation in Reducing Medical Student Debt” 4. D-305.957, “Update on Financial Aid Programs” 5. D-305.962, “Tax Deductibility of Student Loan Payments” 6. D-305.966, “Reinstatement of Economic Hardship Loan Deferment” 7. D-305.970, “Proposed Revisions to AMA Policy on Medical Student Debt” 8. D-305.975, “Long-Term Solutions to Medical Student Debt” 9. D-305.977, “Deductibility of Medical Student Loan Interest” 10. D-305.978, “Mechanisms to Reduce Medical Student Debt” 11. D-305.979, “State and Local Advocacy on Medical Student Debt” 12. D-305.980, “Immediate Legislative Solutions to Medical Student Debt” 13. D-305.981, “Financing Federal Consolidation Loans” 14. D-305.993, “Medical School Financing, Tuition, and Student Debt” 15. D-405.986, “Student Loans and Medicare / Medicaid Participation” 16. H-305.926, “Supporting Legislation to Create Student Loan Savings Accounts” 17. H-305.928, “Proposed Revisions to AMA Policy on Medical Student Debt” 18. H-305.932, “State and Local Advocacy on Medical Student Debt” 19. H-305.948, “Direct Loan Consolidation Program” 20. H-305.954, “Repayment of Medical School Loans” 21. H-305.965, “Student Loans” 22. H-305.980, “Student Loan Repayment Grace Period”   21. H-305.991, “Repayment of Educational Loans” (Rescind HOD Policy) |
| C | CME 06 | n/a | Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours  The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed:   1. That our American Medical Association (AMA) adopt the proposed revisions shown in Appendix A, column 1, for the following three policies:    1. H-310.907, “AMA Duty Hours Policy” (with revised title: “Resident/Fellow Clinical and Educational Work Hours”)    2. H-310.912, “Residents and Fellows’ Bill of Rights”    3. H-310.929, “Principles for Graduate Medical Education” (Modify Current HOD Policy) 2. That our AMA rescind the following seven policies, as shown in Appendix C, and incorporate relevant portions of four of these policies into existing AMA policy:    1. D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety”    2. H-310.922, “Determining Residents’ Salaries”    3. H-310.932, “Annual Contracts for Continuing Residents”    4. H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited Residency Programs”    5. H-310.979, “Resident Physician Working Hours and Supervision”    6. H-310.988, “Adequate Resident Compensation”    7. H-310.999, “Guidelines for Housestaff Contracts or Agreements” (Rescind HOD Policy) |
| C | Res 951 | RFS | Prevention of Physician and Medical Student Suicide  RESOLVED, That our AMA request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events. |
| C | Res 952 | IMG | IMG Section Member Representation on Committees/Task Forces/Councils  RESOLVED, That the American Medical Association ask the Educational Commission for Foreign Medical Graduates (ECFMG) to increase the number of international medical graduates (IMGs) proportionate to the percentage of IMGs serving in the U.S. on their councils, committees, and/or task forces. |
| C | Res 953 | RFS | Support for the Income-Driven Repayment Plans  RESOLVED, That our American Medical Association advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden. |
| C | Res 954 | AAD | VHA GME Funding  RESOLVED, That our American Medical Association continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and be it further  RESOLVED, That our AMA collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration (VHA) funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process; and be it further  RESOLVED, That our AMA oppose service obligations linked to VHA GME residency or fellowship positions, particularly for resident physicians rotating through the VA for only a portion of their GME training. |
| C | Res 955 | MSS | Equality for COMLEX and USMLE  RESOLVED, That our American Medical Association promote equal acceptance of the USMLE and COMLEX at all United States residency programs; and be it further  RESOLVED, That our AMA work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and be it further  RESOLVED, That our AMA work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. |
| C | Res 956 | Nebraska | Increasing Rural Rotations During Residency  RESOLVED, That our American Medical Association work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to encourage and incentivize qualified rural physicians to serve as preceptors, volunteer faculty, etc. for rural rotations in residency; and be it further  RESOLVED, That our AMA work with the ACGME, the American Board of Medical Specialties, the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas; and be it further  RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and be it further  RESOLVED, That our AMA work with state and specialty societies and other interested stakeholders to identify appropriately qualified rural physicians who would be willing to serve as preceptors for rural rotations in residency; and be it further  RESOLVED, That our AMA work with the ACGME and other interested stakeholders to lessen the documentation requirements for off-site rural rotations during residency so that affiliated rural supervising faculty can focus on educating rotating residents; and be it further  RESOLVED, That our AMA work with interested stakeholders to study other ways to increase training in rural areas; and be it further  RESOLVED, That our AMA formulate an actionable plan of advocacy based on the results of the above study with the goal of increasing residency training in rural areas. |
| C | Res 957 | Florida | Board Certifying Bodies  RESOLVED, That our American Medical Association conduct a study of the certifying bodies that compete with the American Board of Medical Specialties and issue a report opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved; and be it further  RESOLVED, That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification. |
| C | Res 958 | California | National Health Service Corps Eligibility  RESOLVED, That our American Medical Association consider eligibility criteria changes for the National Health Service Corps Program to increase the pool of eligible physicians, such as allowing participation from primary care physicians providing in-patient hospitalist care in health professional shortage areas. (Directive to Take Action) |
| C | Res 959 | Indiana | Physician and Medical Student Mental Health and Suicide  RESOLVED, That our American Medical Association create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and mental health disease in physicians and medical students. This committee will be charged with:  1) Developing novel policies to decrease physician and medical trainee stress and improve professional satisfaction.  2) Vociferous, repeated and widespread messaging to physicians and medical students encouraging those with mood disorders to seek help.  3) Working with state medical licensing boards and hospitals to help remove any stigma of mental health disease and to alleviate physician and medical student fears about the consequences of mental illness and their medical license and hospital privileges.  4) Establishing a 24-hour mental health hotline staffed by mental health professionals whereby a troubled physician or medical student can seek anonymous advice. Communication via the 24-hour help line should remain anonymous. This service can be directly provided by the AMA or could be arranged through a third party, although volunteer physician counselors may be an option for this 24-hour phone service. (Directive to Take Action) |
| C | Res 960 | Indiana | Inadequate Residency Slots  RESOLVED, That our American Medical Association adopt policy to establish parity between the number of medical school graduates and the number of match positions and withhold support for any further increase in medical school enrollment, unless there is a corresponding increase in residency positions (New HOD Policy); and be it further  RESOLVED, That our AMA lobby the federal government for increased funding for residency spots, to investigate other sustainable models for residency position funding and to advocate for loan repayment waivers for individuals who fail to match. (Directive to Take Action) |
| C | Res 961 | Michigan | Protect Physician-Led Medical Education  RESOLVED, That our American Medical Association, in their role as a member organization of the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education, strongly advocate for the rights of medical students, residents, and fellows to be trained, supervised, and evaluated by licensed physicians (Directive to Take Action); and be it further  RESOLVED, That our AMA provide medical students, residents, and fellows a clear online resource outlining their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation. (Directive to Take Action) |
| C | Res 962 | Michigan | Improve Physician Health Programs  RESOLVED, That our American Medical Association amend policy D-405.990, “Educating Physicians About Physician Health Programs,” by addition to read as follows:  1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; ~~and~~ 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training; 5) Our AMA will advocate for more independent oversight and regulation of Physician Health Programs (PHPs), by physician groups without any conflict of interest with the participating PHPs; and 6) Our AMA advocate for Physician Health Programs that allow physicians to access more than one type of treatment program. (Modify Current HOD Policy) |
| F | BOT 01 | n/a | Data Used to Apportion Delegates  For these reasons, the Board of Trustees recommends that Resolution 604‑A‑18 not be adopted and the remainder of this report be filed. |
| F | BOT 10 | n/a | Training Physicians in the Art of Public Forum  The Board of Trustees recommends that the AMA’s Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians learn more about public speaking in lieu of Resolution 606-A-18 and the remainder of the report to be filed. |
| F | CLRPD 01 | n/a | Women Physicians Section Five-Year Review  The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Women Physicians Section through 2023 with the next review no later than the 2023 Interim Meeting and that the remainder of this report be filed. |
| F | Res 601\*\* | New England | Creation of an AMA Election Reform Committee  RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the following options:   * The creation of an interactive election web page; * Candidate video submissions submitted in advance for HOD members to view; * Eliminate all speeches and concession speeches during HOD deliberations, with the exception of the President-Elect, Speaker and Board of Trustee positions; * Move elections earlier to the Sunday or Monday of the meeting; * Conduct voting from HOD seats; and be it further   RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns; and be it further  RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019 Interim Meeting with a list of recommendations. |
| F | Res 602\*\* | Indiana | AMA Policy Statement with Editorials  RESOLVED, Our American Medical Association include a policy statement after all editorials in which policy has been established to clarify our position. (Directive to Take Action) |
| F | Res 603 | MAS | Support of AAIP’s “Desired Qualifications for Indian Health Service Director”  RESOLVED, That our American Medical Association support the “Desired Qualifications for the Director of the Indian Health Service” set forth by the Association of American Indian Physicians. (New HOD Policy) |
| J | BOT 09 | n/a | Hospital Closures and Physician Credentialing  The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed:  1. That our American Medical Association (AMA) reaffirm Policy H-230.956, which states that the governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility should be responsible for making arrangements for the disposition of physician credentialing records upon the closing of a facility and should make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, and medical staff status. (Reaffirm HOD Policy)  2. That our AMA develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files.  3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting. |
| J | CMS 01 | n/a | Prescription Drug Importation for Personal Use  The Council on Medical Service recommends that the following be adopted in lieu of Resolution 226-I-17, and that the remainder of the report be filed.   1. That our American Medical Association (AMA) support the in-person purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity. (New HOD Policy) 2. That our AMA advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured. (New HOD Policy) 3. That our AMA reaffirm Policy D-100.983, which outlines criteria for supporting the legalized importation of prescription drug products by wholesalers and pharmacies, and opposes the personal importation of prescription drugs via the Internet until patient safety can be assured. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy D-100.985, which opposes the illegal importation of prescription drugs and drug counterfeiting, and supports working with Congress, federal agencies and other stakeholders to ensure that these illegal activities are minimized. (Reaffirm HOD Policy) |
| J | CMS 02 | n/a | Air Ambulance Regulations and Payments  The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:   1. That our American Medical Association (AMA) amend Policy H-130.954, “Non-Emergency Patient Transportation Systems,” by addition as follows:   The AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.. (Modify Current HOD Policy)   1. That our AMA support increased data collection and data transparency of air ambulance providers and services to the appropriate state and federal agencies, particularly increased price transparency. (New HOD Policy) 2. That our AMA work with relevant stakeholders to evaluate the Airline Deregulation Act as it applies to air ambulances. (New HOD Policy) 3. That our AMA support stakeholders sharing air ambulance best practices across regions. (New HOD Policy) 4. That our AMA rescind Policy D-130.964, which directed the AMA to conduct the study herein. (Rescind AMA Policy) |
| J | CMS 03 | n/a | Sustain Patient-Centered Medical Home Practices  The Council on Medical Service recommends that the following be adopted in lieu of Resolution 813-I-17 and that the remainder of the report be filed:   1. That our American Medical Association (AMA) reaffirm Policy H-160.919 that contains principles of the Patient-Centered Medical Home (PCMH) including that payment should appropriately recognize the added value provided to patients who have a PCMH and the additional physician and team work associated with participating in a PCMH. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-385.908 urging that financial risk should be limited to costs that physicians have the ability to influence or control. (Reaffirm HOD Policy) 3. That our AMA amend Policy, H-160.918, “The Patient-Centered Medical Home,” by addition and deletion as follows:   Our AMA:   * 1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;  1. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources; and 2. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule.~~; and~~ 3. ~~will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home.~~ (Modify Current HOD Policy) 4. That our AMA advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform. (New HOD Policy) 5. That our AMA encourage health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care. (New HOD Policy) |
| J | CMS 04 | n/a | The Site-of-Service Differential  The Council on Medical Service recommends that the following be adopted in lieu of Resolution 817-I-17, and the remainder of the report be filed:   1. That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more aggressive implementation by the US Department of Health and Human Services of existing provisions in federal legislation calling for equity in payment between services provided by hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare & Medicaid Services (CMS) to define Medicare services consistently across settings and adopt payment methodology for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense relative value units reflect the true cost of performing office procedures. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy H-400.966, which directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare. (Reaffirm HOD Policy) 5. That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. (New HOD Policy) 6. That our AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting. (New HOD Policy) 7. That our AMA urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. (New HOD Policy) 8. That our AMA encourage CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. (New HOD Policy) 9. That our AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery. (Directive to Take Action) |
| J | CMS/  CSAPH 01 | n/a | Aligning Clinical and Financial Incentives for High-Value Care  The Council on Medical Service and the Council on Science and Public Health recommend that the following be adopted and that the remainder of the report be filed:   1. That our American Medical Association (AMA) reaffirm Policy H-155.960, which: supports “value-based decision-making” and reducing the burden of preventable disease as broad strategies for addressing rising health care cost; recognizes the important role of physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government in successful cost-containment and quality-improvement initiatives; and encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment, with consideration given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-185.939, which supports flexibility in the design and implementation of Value-Based Insurance Design (VBID) programs and outlines guiding principles including that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements, and that practicing physicians, including appropriate specialists, must be actively involved in the development of VBID programs. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-165.856, which supports a regulatory environment that enables rather than impedes private market innovation in product development and purchasing arrangements. (Reaffirm HOD Policy) 4. That our AMA support VBID plans designed in accordance with the tenets of “clinical nuance,” recognizing that (1) medical services may differ in the amount of health produced, and (2) the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided. (New HOD Policy) 5. That our AMA support initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics. (New HOD Policy) 6. That our AMA develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels. (Directive to Take Action) 7. That our AMA develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient. (Directive to Take Action) 8. That our AMA continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients. (New HOD Policy) 9. That our AMA continue to support implementing innovative VBID programs in Medicare Advantage plans. (New HOD Policy) 10. That our AMA support legislative and regulatory flexibility to accommodate VBID that   (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive services; and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services. (New HOD Policy)   1. That our AMA encourage national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. (New HOD Policy) |
| J | Res 801 | MSS | Encourage Final Evaluation Reports of Section 1115 Demonstrations at the End of the Demonstration Cycle  RESOLVED, That our American Medical Association encourage the Centers for Medicare & Medicaid Services to establish written procedures that require final evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status. |
| J | Res 802 | New England | Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk)  RESOLVED, That our American Medical Association advocate for the continuation of up side only risk Medicare Shared Savings ACO (MSSP ACO) program as an option from the Centers for Medicare and Medicaid Services, particularly for physician owned groups; and be it further  RESOLVED, That our AMA develop educational resources and business analytics to help physicians complete due diligence in evaluating the performance of hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software; and be it further  RESOLVED, That our AMA evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and organizational tools needed to allow smaller practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs. |
| J | Res 803 | RFS | Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogram  RESOLVED, That our American Medical Association support insurance coverage for supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician; and be it further  RESOLVED, That our AMA advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician. |
| J | Res 804 | Alaska | Arbitrary Documentation Requirements for Outpatient Services  RESOLVED, That our American Medical Association agree that documentation for outpatient physician services should be completed in a timely manner; and be it further  RESOLVED, That for circumstances in which more specific definitions of timeliness are required, AMA policy is that documentation for outpatient services should be completed, when possible, within 14 days of a provided service; and be it further  RESOLVED, That our AMA work with government health plans and private insurers to help them better understand the unintended consequences of imposing documentation rules with unrealistically short timeframes, and that our AMA oppose the use of such rules or regulations in determining whether submitted claims are valid and payable. |
| J | Res 805 | Florida | Prompt Pay  RESOLVED, That American Medical Association Policy H-190.959 be amended as follows:  Physician Reimbursement by Health Insurance and Managed Care Companies  1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within ~~fourteen~~ three days. 2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within ~~five~~ one business day~~s~~ to allow prompt resubmission of a clean claim. 3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. |
| J | Res 806 | AMDA | Telemedicine Models and Access to Care in Post-Acute and Long-Term Care  RESOLVED, That our American Medical Association advocate for removal of arbitrary limits on telemedicine visits by medical practitioners in nursing facilities and instead base them purely on medical necessity, and collaborate with AMDA – The Society for Post-Acute and Long-Term Care Medicine to effect a change in Medicare’s policy regarding this matter under the provisions of Physician Fee Schedule (PFS) and Quality Payment Program (QPP) (New HOD Policy); and be it further  RESOLVED, That our AMA work with AMDA-The Society for Post-Acute and Long-Term Care Medicine and other stakeholders to influence Congress to broaden the scope of telemedicine care models in post-acute and long-term care and authorize payment mechanisms for models that are evidence based, relevant to post-acute and long-term care and continue to engage primary care physicians and practitioners in the care of their patients. (Directive to Take Action) |
| J | Res 807 | ACEP | Emergency Department Copayments for Medicaid Beneficiaries  RESOLVED, That our American Medical Association oppose imposition of copays for Medicaid beneficiaries seeking care in the emergency department. (New HOD Policy) |
| J | Res 808 | Tennessee | The Improper Use of Beers or Similar Criteria and Third-Party Payer Compliance Activities (H-185.940)  RESOLVED, That our American Medical Association identify and establish a workgroup with insurers that are inappropriately applying Beers or similar criteria to quality rating programs and work with the insurers to resolve internal policies that financially penalize physicians (Directive to Take Action); and be it further  RESOLVED, That our AMA study and report back to the House of Delegates the 2019 Interim Meeting, the potential inappropriate use of Beers Criteria by insurance companies looking at which companies are involved and the effect of the use of these criteria on physicians’ practices (Directive to Take Action); and be it further  RESOLVED, That our AMA provide a mechanism for members to report possible abuses of Beers Criteria by insurance companies. (Directive to Take Action) |
| J | Res 809 | ASCO | Medicaid Clinical Trials Coverage  RESOLVED, That our American Medical Association actively lobby for and support federal legislation that guarantees coverage of routine patient care costs for Medicaid enrollees who participate in clinical trials. (Directive to Take Action) |
| J | Res 810 | ASCO | Medicare Advantage Step Therapy  RESOLVED, That our American Medical Association continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019. (Directive to Take Action) |
| J | Res 811 | ASRM | Infertility Benefits for Active-Duty Military Personnel  RESOLVED, That our American Medical Association work with the Department of Defense, the American Society for Reproductive Medicine and other interested organizations to inform beneficiaries regarding the current availability of low-cost infertility care and gamete cryopreservation services at military treatment facilities for active-duty military personnel under Tricare (Directive to Take Action); and be it further  RESOLVED, That our AMA work with the American Society for Reproductive Medicine (and the American College of Obstetricians and Gynecologists (ACOG) and the American Urological Association (AUA)) and other interested organizations to encourage Tricare to fully cover infertility diagnosis and treatment for active-duty military personnel and others covered by Tricare (Directive to Take Action); and be it further  RESOLVED, That our AMA work with the American Society for Reproductive Medicine (and ACOG and AUA) and other interested organizations to encourage Tricare to fully cover gamete preservation prior to deployment for active-duty military personnel (Directive to Take Action); and be it further  RESOLVED, That our AMA report back on this issue at the 2019 Interim Meeting. (Directive to Take Action) |
| J | Res 812 | Craig Backs, delegate | ICD Code for Patients Harm From Payer Interference  RESOLVED, That our American Medical Association support the creation and implementation of an ICD code(s) to identify administrator or payer influence that affects treatment and leads to or contributes to, directly or indirectly, patient harm. (New HOD Policy) |
| J | Res 813 | Indiana | Direct Primary Care Health Savings Account Clarification  RESOLVED, That our American Medical Association seek federal changes to the Internal Revenue Code allowing health savings accounts to be used with direct primary care. (Directive to Take Action) |
| J | Res 814 | Indiana | Prior Authorization Relief in Medicare Advantage Plans  RESOLVED, That our American Medical Association support legislation that would apply the following legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:  - Listing services that require a PA on a website.  - Notifying providers of any changes at least 45 days prior to change.  - Standardizing a PA request form.  - Not denying payment for PA that has been approved unless fraudulently obtained or ineligible at time of service.  - Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans (New HOD Policy); and be it further  RESOLVED, That our AMA apply these same legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include:  - Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician.  - Minimizing PA requirements as much as possible within each plan.  - Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider. (New HOD Policy) |
| J | Res 815 | Indiana | Uncompensated Physician Labor  RESOLVED, That our American Medical Association adopt policy that physicians should be compensated for reviewing and responding to new after-hour patient messages. (New HOD Policy) |
| J | Res 816 | Indiana | Medicare Advantage Plan Inadequacies  RESOLVED, That our American Medical Association investigate the deficiencies of Medicare Advantage plans, with the goal of improving nursing home, rehab and physical therapy benefits. Full transparency about the cost and coverage of the plan, as well as communication about plan limitations, should be required (Directive to Take Action); and be it further  RESOLVED, That our AMA issue an opinion on whether Medicare Advantage plans should be limited to healthier seniors with both a short problem list and short medication list, and whether there should be a cap on administrative costs for these plans. (Directive to Take Action) |
| J | Res 817 | Indiana | Increase Reimbursement for Psychiatric Services  RESOLVED, That our American Medical Association support increasing reimbursement for psychiatric services through direct funding adjustments or the CPT Editorial Panel process. |
| J | Res 818 | Indiana | Drug Pricing Transparency  RESOLVED, That our American Medical Association advocate to the U.S. Surgeon General for federal legislation that investigates all drug pricing. |
| J | Res 819 | Michigan | Medicare Reimbursement Formula for Oncologists Administering Drugs  RESOLVED, That our American Medical Association amend policy H-55.994 by addition to read as follows:  Coverage of Chemotherapy in Physicians' Offices H-55.994  The AMA: (1) supports adequate reimbursement for outpatient oncology office visits that recognizes the complexity of the patient’s care management; and (2) advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA advocate for a change to the Medicare reimbursement formula such that the costs of chemotherapeutic agents are covered, plus an unrelated flat fee to cover the cost of the infusion or injection of said agents. |
| J | Res 820 | Michigan | Ensuring Quality Health Care for Our Veterans  RESOLVED, That our American Medical Association amend policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:  Ensuring Access to Safe and Quality Care for our Veterans H-510.986  1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.  2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.  3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.  4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.  5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains first-rate, competent, and ethical physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.  6. Our AMA will engage the Veterans Health Administration in dialogue on accreditation practices by the Veterans Health Administration to assure they are similar to those of hospitals, state medical boards, and insurance companies. |
| J | Res 821 | Michigan | Direct Primary Care and Concierge Medicine Based Practices  RESOLVED, That our American Medical Association actively lobby for revision to the U.S. tax code to allow funds from health savings accounts to be used for concierge medicine and direct primary care without incurring a tax penalty. |
| K | BOT 12 | n/a | Information Regarding Animal-Derived Medications  The Board of Trustees recommends the following be adopted in lieu of Resolution 515-A-18, and the remainder of the report be filed:  Animal-Derived Ingredients  Our AMA:  1. Urges the U.S. Food and Drug Administration to require manufacturers to include all ingredients and components present in medical products on the product label, including both active and inactive ingredients, and denote any derived from an animal source.  2. Encourages cultural awareness regarding patient preferences associated with medical products containing active or inactive ingredients or components derived from animal sources. |
| K | CSAPH 01 | n/a | Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals  The Council on Science and Public Health recommends that the following statements be adopted and the remainder of the report be filed:   1. That Policy D-515.980, “Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals” be amended by addition and deletion to read as follows:   Our AMA will: (1) ~~study recent domestic violence data and the unique issues faced by the LGBTQ population; and (2)~~ promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ ~~victims~~ survivors of domestic violence, (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of intimate partner violence, and (3) advocate for federal funding to support programs and services for survivors of intimate partner violence that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity. (Modify Current HOD policy)   1. Our AMA encourages research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. (New HOD Policy) 2. That Policy H-160.991, “Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations,” be reaffirmed.   Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors. (Reaffirm HOD Policy) |
| K | CSAPH 02 | n/a | FDA Expedited Review Programs and Processes  The Council on Science and Public Health recommends that Policy H-100.992 be amended by addition and deletion to read as follows in lieu of Res-201-I-17, and the remainder of the report be filed:  (1) Our AMA ~~reaffirms its~~ supports ~~for~~ the principles that:  (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute;  (b) the~~is~~ evidence for drug approval should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies;  (c) expedited programs for drug approval serve the public interest as long as sponsors for drugs that are approved based on surrogate endpoints or limited evidence conduct confirmatory trials in a timely fashion to establish the expected clinical benefit and predicted risk-benefit profile;  (d) confirmatory trials for drugs approved under expedited programs should be planned and underway at the time of expedited approval;  (e) the FDA should pursue having in place a systematic process to ensure that sponsors adhere to their obligations for confirmatory trials, and Congress should establish a firmer threshold to trigger expedited withdrawal when sponsors fail to fulfill their postmarketing study obligations;  (~~d~~ f) any risk-benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications; and,  (g) FDA should consider a simple system to assign a grade for each approval of prescription drugs occurring via expedited programs in order to signal, and provide in a transparent manner, the quality of clinical trial evidence used to establish safety and effectiveness, and whether confirmatory trials are required for labeled indications.  (2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.  (3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. |
| K | Res 901 | MSS | Support for Preregistration in Biomedical Research  RESOLVED, That our American Medical Association support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research. |
| K | Res 902 | MSS | Increasing Patient Access to Sexual Assault Nurse Examiners  RESOLVED,That our American Medical Association advocate for increased patient access to sexual assault nurse examiners in the emergency department. |
| K | Res 903 | MSS | Regulating Front-of-Package Labels on Food Products  RESOLVED, That our American Medical Association support additional U.S. Food and Drug Administration criteria that limit the amount of added sugar a food product can contain if it carries any front-of-package label advertising nutritional or health benefits; and be it further  RESOLVED, That our AMA support the use of front-of-package warning labels on foods that contain excess added sugar. |
| K | Res 904 | MSS | Support for Continued 9-1-1 Modernization and the National Implementation of Text-to-911 Service  RESOLVED, That our American Medical Association support the funding of federal grant programs for the modernization of the 9-1-1 infrastructure, including incorporation of text to 911 technology. |
| K | Res 905 | MSS | Support Offering HIV Post Exposure Prophylaxis to All Survivors of Sexual Assault  RESOLVED, That our American Medical Association advocate for education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines; and be it further  RESOLVED, That our AMA support increased public education about the effective use of Post-Exposure Prophylaxis for HIV; and be it further  RESOLVED, That our AMA amend policy H-20.900 by addition and deletion as follows:  H-20.900, “HIV, Sexual Assault, and Violence”  Our AMA believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all ~~victims~~ survivors of sexual assault, that these ~~victims~~ survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained. |
| K | Res 906 | MSS | Increased Access to Identification Cards for the Homeless Population  RESOLVED, That our American Medical Association recognize that among the homeless population, lack of identification serves as a barrier to accessing medical care and fundamental services that support health; and be it further  RESOLVED, That our AMA support legislative and policy changes that streamline, simplify, and reduce or eliminate the cost of obtaining identification cards for the homeless population. |
| K | Res 907\*\* | MSS | Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing  RESOLVED, That our American Medical Association support research on problematic pornography use, including its physiological and environmental drivers, appropriate diagnostic criteria, effective treatment options, and relationships to erectile dysfunction and domestic violence. |
| K | Res 908 | MSS | Increasing Accessibility to Incontinence Products  RESOLVED, That our American Medical Association support increased access to affordable incontinence products. |
| K | Res 909\*\* | Wisconsin | Use of Person-Centered Language  RESOLVED, That our American Medical Association encourage the use of person-centered language. |
| K | Res 910\*\* | New England | Shade Structures in Public and Private Planning and Zoning Matters  RESOLVED, That our American Medical Association support sun shade structures (such as awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical importance of sun protection as a public health measure. |
| K | Res 911 | RFS | Regulating Tattoo and Permanent Makeup Inks  RESOLVED, That our American Medical Association encourage the Food and Drug Administration to adopt regulatory standards for tattoo and permanent makeup inks that include at minimum the disclosures expected for injectable drugs and cosmetics and mandate that this information be available to both the body licensed to perform the tattoo and to the person receiving the tattoo; and be it further  RESOLVED, That our AMA study the safety of any chemical in tattoo and permanent makeup inks. |
| K | Res 912 | RFS | Comprehensive Breast Cancer Treatment  RESOLVED, That our AMA amend Policy H-55.973, “Breast Reconstruction,” by addition and deletion as follows:  Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the ~~postmastectomy cancer~~ post-treatment patient with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. |
| K | Res 913 | WPS | Addressing the Public Health Implications of Pornography  RESOLVED, That our American Medical Association support efforts to mitigate the negative public health impacts of pornography as it relates to vulnerable populations, including but not limited to women and children. |
| K | Res 914 | AAPHP | Common Sense Strategy for Tobacco Control and Harm Reduction  RESOLVED, That our American Medical Association advocate for a “protect adult choice and youth’s health” “common sense” tobacco strategy (with a report back to the House of Delegates annually) under which:  - Current educational, promotional and policy initiatives (e.g. taxation) to reduce the use of tobacco products by inhalation and orally would continue, including advocating for the prohibition of the sale of ALL nicotine containing products to individuals under 21 years unless via prescription for medical purposes.  - E-cigarettes (non-tobacco products containing nicotine) would be accessible at an affordable price to adults who wish to use them, and would be available to individuals below 21 years of age only as part of state sanctioned tobacco cessation activities. States and local jurisdictions would be free to require vendors to post warnings regarding the possible health risks of the use of nicotine inhalation products.  - Non-nicotine, non-drug containing vaping and other inhalation products would not be considered tobacco products, but would be monitored by state and local jurisdictions as any other personal use product regarding safety and public accommodation. |
| K | Res 915 | ACEP | Mandatory Reporting  RESOLVED, That our American Medical Association oppose mandated reporting of entire classes of patients and specific diagnoses unless compelling evidence exists to demonstrate that a serious public health and/or safety risk will be mitigated as a result of such reporting. (New HOD Policy) |
| K | Res 916 | ATS | Ban on Tobacco Flavoring Agents with Respiratory Toxicity  RESOLVED, That our American Medical Association call for the immediate ban on flavoring agents in ENDS and other tobacco products that have known respiratory toxicity including but not limited to diacetyl, 2,3 pentanedione, acetoin, cinnamaldehyde, banzaldehyde, eugenol, vanillin/ethyl vanillin, and menthol (Directive to Take Action); and be it further  RESOLVED, That our AMA urge the Food and Drug Administration (FDA) to require comprehensive testing of flavoring agents used in electronic nicotine delivery systems (ENDS) and other tobacco products to assess the potential negative health effects of chronic exposure to these flavoring agents. (Directive to Take Action) |
| K | Res 917 | ATS | Protect and Maintain the Clean Air Act  RESOLVED, That our American Medical Association oppose provisions of the Affordable Clean Energy proposed rule that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase (New HOD Policy); and be it further  RESOLVED, That our AMA send a letter to the Environmental Protection Agency (EPA) expressing our opposition to EPA’s Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act. (Directive to Take Action) |
| K | Res 918 | Indiana | Allergen Labeling on Food Packaging  RESOLVED, That our American Medical Association petition the Food and Drug Administration to pursue more obvious labeling on food packaging containing the eight most common food allergens: milk, eggs, peanuts, tree nuts, wheat, soy, fish and crustacean shellfish. (Directive to Take Action) |
| K | Res 919 | Indiana | Opioid Mitigation  RESOLVED, That our American Medical Association review the following opioid mitigation strategies based on their effectiveness in Huntington, WV, and Clark County, IN, and provide feedback concerning their utility in dealing with opioids:  (1) The creation of an opioid overdose team that decreases the risk of future overdose and overdose death, increases access to opioid-related services and increases the likelihood that an individual will pursue drug rehabilitation.  (2) A needle exchange program that is open multiple days a week and is mobile offers not only a source for needles but also Narcan, other supplies, health care and information.  (3) The creation of a drug court that allows a judge to have greater flexibility in determining the legal consequences of an arrest for an opioid-related crime. It also allows for the judicial patience necessary to deal with the recidivism of this population.  (4) Offering more acute-care inpatient drug rehab beds, although those ready for treatment need to be willing to travel significant distances to get to a treatment bed.  (5) Make available Narcan intranasal spray OTC through pharmacies and the syringe exchange, overdose team, etc.  (6) Encourage prevention education in K-12 programs that uses multiple media with anti-drug messaging delivered in the school system but also in the home. (Directive to Take Action) |
| K | Res 920 | Michigan | Continued Support for Federal Vaccination Funding  RESOLVED, That our American Medical Association release a public statement of support for federal vaccination funding efforts such as Section 317, and actively advocate for sustained funding. (Directive to Take Action) |
| K | Res 921 | Michigan | Food Environments and Challenges Accessing Healthy Food  RESOLVED, That our American Medical Association work with appropriate stakeholders to advocate for the study of the national prevalence and impact of food mirages, food swamps, and food oases as food environments distinct from food deserts. (Directive to Take Action) |

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| **Reference committees of the House of Delegates** | **AMA councils** |
| **Con = Reference Committee on Amendments to Constitution and Bylaws** | **CCB = Constitution and Bylaws** |
| **B = Reference Committee B** | **CEJA = Ethical and Judicial Affairs** |
| **C = Reference Committee C** | **CLRPD = Long Range Planning and Development** |
| **F = Reference Committee F** | **CME = Medical Education** |
| **J = Reference Committee G** | **CMS = Medical Service** |
| **K = Reference Committee K** | **CSAPH = Science and Public Health** |

† Only the first organization is listed for those resolutions sponsored by multiple entities

\*\* Resolution recommended against consideration at I-18.