Abridged Handbook

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.

| **Cmte\*** | **Item** | **Title / Recommendations or Resolves** |
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| .Con | BOT 02 | New Specialty Organizations Representation in the House of DelegatesTherefore, the Board of Trustees recommends that the American Academy of Sleep Medicine and the American Society of Cytopathology be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action) |
| .Con | BOT 26 | Research Handling of De-Identified Patient Information1. That our American Medical Association (AMA) reaffirm Policies H-315.974, “Guiding Principles, Collection and Warehousing of Electronic Medical Record Information,” H‑315.983, “Patient Privacy and Confidentiality,” H-315.975, “Police, Payer, and Government Access to Patient Health Information,” H-315.978, “Privacy and Confidentiality,” and H‑315.987, “Limiting Access to Medical Records.” (Reaffirm HOD Policy)2. That our AMA support state-based efforts to protect patient privacy including the patient’s right to know whether information is being disclosed or sold and to whom and the right to opt out of the sale of their data. (New HOD Policy)3. That our Council on Ethical and Judicial Affairs consider re-examining existing guidance relevant to the confidentiality of patient information in light of new practices regarding de-identified patient data, including the use of exclusive de-identified data licensing agreements in healthcare. (Directive to Take Action)4. That Policy D-315.975, “Research Handling of De-Identified Patient Information,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy) |
| .Con | CCB 01 | Clarification to the Bylaws: Delegate Representation, Registration and CredentialingThe Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted; and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.**2.0.1 Composition and Representation.** The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw.**2.0.1.1 Qualification of Members of the House of Delegates.** Members of the House of Delegates must be active members of the AMA and of the entity they represent.\*\*\***2.1 Constituent Associations.** Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seats as may be provided under Bylaw 2.1.1.2. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.\*\*\***2.1.4 Certification.** The president ~~or secretary~~ of each constituent association or the president’s designee shall certify to the AMA the delegates and alternate delegates from their respective associations. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates.**\*\*\*****2.2 National Medical Specialty Societies.** The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies.Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seat as may be provided under Bylaw 2.2.2. The total number of delegates apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 and 2.1.1.1.1 using methods specified in AMA policy.\*\*\***2.2.4 Certification.** The president ~~or secretary~~ of each specialty society or the president’s designee shall certify to the AMA the delegates and alternate delegates from their respective societies. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates.**\*\*\*****2.3 Medical Student Regional Delegates.** ~~In addition to the delegate and alternate delegate representing the Medical Student Section, regional~~ M~~m~~edical student regional delegates and alternate delegates shall be apportioned and elected as provided in this bylaw. Medical student regional delegates and alternate delegates represent the constituent association that endorsed their candidacy pursuant to bylaw 2.3.3.**2.3.1 Qualifications.** Medical ~~S~~student ~~R~~regional delegates and alternate delegates must be active medical student members of the AMA and attend medical school in the medical student region from which they seek election. In addition, medical student regional delegates and alternate delegates must be members of the constituent association in the state wherein their educational program is located.2.3.1.1 Medical student regional alternate delegates may substitute for delegates in their same region in accordance with 2.8.5 and 2.10.4.**2.3.2 Apportionment.** The total number of ~~M~~medical ~~S~~student ~~R~~regional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each ~~M~~medical ~~S~~student ~~R~~region, as defined by the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the ~~M~~medical ~~S~~student ~~R~~region….\*\*\***2.3.3 Election.** Medical ~~S~~student ~~R~~regional delegates and alternate delegates shall be elected by the Medical Student Section in accordance with procedures adopted by the Section. Each elected delegate and alternate must receive written endorsement from the constituent association representing the jurisdiction within which the medical student’s educational program is located, in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. Delegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting of the House of Delegates. Delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.**2.3.4 Certification.** The Chair of the Medical Student Section Governing Council or the Chair’s designee shall certify to the AMA the delegates and alternate delegates ~~for~~ from each ~~M~~medical ~~S~~student ~~Rr~~egion. Certification of delegates and alternate delegates must occur at least 30 days prior to the Annual Meeting of the House of Delegates.**2.4 Delegates from the Resident and Fellow Section.** In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.**2.4.1 Qualifications.** Delegates and alternate delegates from the Resident and Fellow Section must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow physician delegates and alternate delegates must be members of their endorsing constituent association, national medical specialty society, federal service or professional interest medical association.**2.4.2 Apportionment.** The apportionment of delegates from the Resident and Fellow Section is one delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.**2.4.3 Election.** Delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with procedures adopted by the Section. Each delegate and alternate delegate must receive written endorsement from ~~his or her~~ a constituent association, ~~or~~ national medical specialty society, federal service or professional interest medical association in accordance with procedures adopted by the Resident and Fellow Section and approved by the Board of Trustees.**2.4.4 Certification.** The Chair of the Resident and Fellow Section Governing Council or ~~his or her~~ the Chair’s designee shall certify to the AMA the delegates and alternate delegates for the Resident and Fellow Section. Certification of delegates and alternate delegates must occur at least 30 days prior to the Annual Meeting of the House of Delegates.**\*\*\*****2.6 Other Delegates.** Each of the following is entitled to a delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women’s Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.**2.6.1 Certification.** The president~~, secretary~~ or other authorized individual of each entity shall certify to the AMA their respective delegate and alternate delegate. Certification must occur 30 days prior to the Annual or Interim Meeting.**2.8 Alternate Delegates.** Each organization represented in the House of Delegates may select an alternate delegate for each of its delegates entitled to be seated in the House of Delegates.**2.8.1 Qualifications.** Alternate delegates must be active members of the AMA and of the entity they represent.**\*\*\*****2.8.5 Rights and Privileges.** An alternate delegate may substitute for a delegate~~,~~ on the floor of the House of Delegates, at the request of the delegate by complying with the procedures established by the Committee on Rules and Credentials. While briefly substituting for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote on all matters other than elections. If a delegate needs a substitute for more than half a day, then an alternate delegate must be properly recredentialed as the delegate in accordance with Bylaw 2.10.4. An alternate delegate who has been properly recredentialed as the delegate in accordance with Bylaw 2.10.4 is then considered a member of the House of Delegates, with all the rights and privileges of a delegate.**2.8.6 Status.** The alternate delegate is not a “member of the House of Delegates” as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates, nor vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. ~~The~~ An alternate delegate must immediately relinquish his or her position on the floor of the House of Delegates upon the request of the delegate for whom the alternate delegate is briefly substituting.\*\*\***2.10 Registration and Seating of Delegates.****\*\*\*****2.10.2 Credentials.** A delegate or alternate delegate representing a constituent association or a national medical specialty society may only be seated if there is ~~Before being seated at any meeting of the House of Delegates, each delegate or alternate delegate shall deposit with the Committee on Rules and Credentials~~ a certificate on file submitted ~~signed~~ by the president~~,~~ or the president’s designee. ~~secretary, or~~ A delegate or alternate delegate representing a section, federal service or professional interest medical association may only be seated if there is a certificate on file submitted by the section chair or other authorized individual. All certificates must ~~other authorized individual of the delegate’s or alternate delegate’s organization~~ state~~ing~~ that the delegate or alternate delegate has been properly selected to serve in the House of Delegates.**2.10.3 Lack of Credentials.** A delegate or alternate delegate may be seated without the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or alternate delegate selected by the respective organization is established, and so certified to the AMA by the organization’s president, the president’s designee or other authorized individual.**2.10.4 Substitute.** When a delegate or alternate delegate is unable to attend a meeting of the House of Delegates, the ~~appropriate authorities~~ president, the president’s designee or other authorized individual of the organization or section may appoint a substitute delegate or substitute alternate delegate prior to the first meeting of the Committee on Rules and Credentials, who ~~on presenting proper credentials~~ shall be eligible to serve as such delegate or alternate delegate in the House of Delegates at that meeting.**2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that delegate’s place may be taken during the period of absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must ~~comply with the formal recredentialing procedures established by the Committee on Rules and Credentials for such purpose~~ have a certification on file submitted by the president, the president’s designee or other authorized individual of the organization or Section, and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.**2.10.5 Constituent Association President.** The current president of a constituent association may also be certified as an additional alternate delegate at the discretion of each constituent association. Certification must occur at least 30 days prior to the Annual or Interim meeting of the House of Delegates.**2.10.6 President of a National Medical Specialty Society or Professional Interest Medical Association.** The current president of a national medical specialty society or professional interest medical association may also be certified as an additional alternate delegate at the discretion of each national medical specialty society and professional interest medical association with representation in the House of Delegates. Certification must occur at least 30 days prior to the Annual or Interim meeting of the House of Delegates.**2.10.~~6~~7 Representation.** No delegate or alternate delegate may be ~~registered~~ credentialed or seated at any meeting to represent more than one organization in the House of Delegates.**2.10.~~7~~8 Medical Student Seating.** Each ~~M~~medical ~~S~~student ~~R~~regional delegate shall be seated with the constituent association representing the jurisdiction within which such delegate’s educational program is located.**2.10.~~8~~**~~9~~ **Resident and Fellow Seating.** Each delegate from the Resident and Fellow Section shall be seated with the physician’s endorsing constituent association, ~~or~~ specialty society, federal service or professional interest medical association. In the case where a delegate has been endorsed by multiple associations ~~both a constituent association and specialty society~~, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated. |
| .Con | CEJA 01 | Competence, Self-Assessment and Self-AwarenessThe 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:(a) 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 on physicians’ responsibilities to impaired colleagues.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 | Physician-Assisted SuicideThe 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.Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide, and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support assisted suicide, the Council on Ethical and Judicial Affairs 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 | Res. 001 | Opposing Attorney Presence at and/or Recording of Independent Medical ExaminationsIllinoisRESOLVED, That our American Medical Association amend Policy H-365.981, “Workers’ Compensation,” by addition to read as follows:Our AMA:(1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development.(2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.(3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.(4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.(5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.(6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.(7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.(8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.(9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.(10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.(11) opposes the ability of courts to compel recording and videotaping of, or allow a court reporter or an opposing attorney to be present during, the independent medical examination, as a condition for the physician’s medical opinions to be allowed in court. (Modify Current HOD Policy); and be it furtherRESOLVED, That revised AMA Policy H-365.981, “Workers Compensation,” be included in the AMA’s *Guide to the Evaluation of Permanent Impairment*. (New HOD Policy) |
| .Con | Res. 002 | Addressing Existential Suffering in End-of-Life CareMinnesotaRESOLVED, That our American Medical Association ask the Council on Judicial and Ethical affairs to review Ethical Opinion 5.6, “Sedation to Unconsciousness in End-of-Life Care,” to address the following two issues: appropriate treatments beyond social, psychological or spiritual support to treat existential suffering, and the recognition of a patient’s previously expressed wishes with end-of-life care. (Directive to Take Action) |
| .Con | Res. 003 | Conforming Sex and Gender Designation on Government IDs and Other DocumentsGLMA: Health Professionals Advancing LGBTQ EqualityRESOLVED, That our American Medical Association modify HOD Policy H-65.967, “Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients,” by addition and deletion to read as follows:Conforming ~~Birth Certificate Policies to Current Medical Standards for Transgender Patients~~ Sex and Gender Designation on Government IDs and Other Documents (H-65.967)1. Our AMA supports ~~policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care~~ every individual’s right to determine their gender identity and sex designation on government documents and other forms of government identification.2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual’s gender identity, as reported by the individual and without need for verification by a medical professional.3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to “male” and “female.”4. Our AMA~~: (a) supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates; and (b) supports that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventive care~~ supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual’s needs. (Modify Existing Policy) |
| .Con | Res. 004 | Reimbursement for Care of Practice Partner RelativesNew YorkRESOLVED, That our American Medical Association support changes in the Medicare guidelines to allow a physician, who is a partner in the practice, to care for and receive appropriate reimbursement for immediate relatives of one of the other partners in their practice. (Directive to Take Action) |
| .Con | Res. 005 | Right for Gamete Preservation TherapiesNew YorkRESOLVED, That fertility preservation services be officially recognized by our American Medical Association as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies (New HOD Policy); and be it furtherRESOLVED, That our AMA officially support the right of transgender or non-binary individuals to seek gamete preservation therapies. (New HOD Policy) |
| .Con | Res. 006 | Use of Person-Centered LanguageWisconsinRESOLVED, That our American Medical Association encourage the use of person-centered language. (New HOD Policy) |
| .Con | Res. 007 | Delegation of Informed ConsentResident and Fellow SectionRESOLVED, That our American Medical Association in cooperation with other relevant stakeholders advocate that a qualified physician be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient’s condition, and the procedures to be performed on the patient (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the implications of the *Shinal v. Toms* ruling and its potential effects on the informed consent process. (Directive to Take Action) |
| .Con | Res. 008# | Preventing Anti-Transgender ViolenceMinority Affairs SectionRESOLVED, That our American Medical Association partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual’s birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual’s birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience (Directive to Take Action); and be it furtherRESOLVED, That our AMA issue a press release following the conclusion of the annual House of Delegates meeting with updates to be published in both scientific and mainstream publications regarding the prevalence of physical and mental health conditions and barriers faced by the LGBTQ community. (Directive to Take Action) |
| .Con | Res. 009# | References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and HarassmentMinority Affairs SectionRESOLVED, That our American Medical Association undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not (Directive to Take Action); and be it furtherRESOLVED, That our AMA research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment (Directive to Take Action); and be it furtherRESOLVED, That our AMA present the preliminary study results the Minority Affairs Section, the Women’s Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment (Directive to Take Action); and be it furtherRESOLVED, That our American Medical Association produce a report within 18 months with study results and recommendations. (Directive to Take Action) |
| .Con | Res. 010# | Covenants Not to CompeteNew MexicoRESOLVED, That our American Medical Association consider as the basis for model legislation the New Mexico statute allowing a requirement that liquidated damages be paid when a physician partner who is a part owner in practice is lured away by a competing hospital system (Directive to Take Action); and be it furtherRESOLVED, That our AMA ask our Council on Ethical and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case of a physician partner who is a part owner of a practice, in light of the protection that liquidated damages can confer to independent physician owned partnerships, and because a requirement to pay liquidated damages does not preclude a physician from continuing to practice in his or her community. (Directive to Take Action) |
| .Con | Res. 011# | Mature Minor Consent to VaccinationsMichiganRESOLVED, That our American Medical Association amend the policy H-440.830, “Education and Public Awareness on Vaccine Safety and Efficacy,” by addition as follows:Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; ~~and~~ (f) supports state policies allowing adolescents to provide their own consent for vaccination and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and, (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths. (Modify Current HOD Policy) |
| .Con | Res. 012# | Improving Body Donation RegulationMedical Student SectionRESOLVED, That our American Medical Association recognize the need for ethical, transparent, and consistent body donation regulations. (New HOD Policy) |
| .Con | Res. 013# | Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration CourtMedical Student SectionRESOLVED, That our American Medical Association advocate that healthcare services provided to minors in immigrant detention focus solely on the health and well-being of the children (Directive to Take Action); and be it furtherRESOLVED, That our AMA condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. (Directive to Take Action) |
| .Con | Res. 014# | Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy OrganizationsMedical Student SectionRESOLVED, That our American Medical Association support guidelines for members of the Federation of Medicine and patient advocacy organizations to disclose donations, sponsorships, and other financial transactions by industry and commercial stakeholders. (New HOD Policy) |
| .Con | Res. 015# | Opposing Mandated Reporting of People Who Question Their Gender IdentityMedical Student SectionRESOLVED, That our American Medical Association oppose mandated reporting of youth who question or express interest in exploring their gender identity. (New HOD Policy) |
| .Con | Res. 016# | Sexual and Gender Minority Populations in Medical ResearchMedical Student SectionRESOLVED, That our American Medical Association amend policy H-315.967, “Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation,” by addition and deletion as follows:Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical DocumentationOur AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of ~~sexual orientation/gender identity~~ sexual orientation, gender identity, and other sexual and gender minority traits such as differences/disorders of sex development for the purposes of research into patient and population health. (Modify Current HOD Policy) |
| .Con | Res. 017# | National Guidelines for GuardianshipMedical Student SectionRESOLVED, That our American Medical Association collaborate with relevant stakeholders to advocate for federal creation and adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures. (Directive to Take Action) |
| .Con | Res. 018# | Support for Requiring Investigations into Deaths of Children in Foster CareMedical Student SectionRESOLVED, That our American Medical Association support legislation requiring investigations into the deaths of children in the foster care system that occur while the child is in the foster care system. (New HOD Policy) |
| .Con | Res. 019# | Opposition to Requirements for Gender-Based Medical Treatments for AthletesMedical Student SectionRESOLVED, That our American Medical Association oppose any regulations requiring mandatory medical treatment or surgery for athletes with Differences of Sex Development (DSD) to be allowed to compete in alignment with their identity (Directive to Take Action); and be it furtherRESOLVED, That our AMA oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions. (Directive to Take Action) |
| .Con | Res. 020# | Request to the AMA Council on Ethical and Judicial Affairs (CEJA) to Consider Specific Changes to the Code of Medical Ethics Opinion E-5.7, “Physician-Assisted Suicide”, in Order to Remove Inherent Conflicts Within the Code, to Delete Pejorative, Stigmatizing Language, and to Adopt an Ethical Position of Engaged NeutralityNew MexicoRESOLVED, That our American Medical Association Council on Judicial and Ethical Affairs be strongly encouraged to remove from the Code of Medical Ethics Opinion E-5.7 “Physician-Assisted Suicide” judgmental, stigmatizing language that is not evidence based, is at odds with the conclusions of CEJA Report 2 in recognizing shared values of care, compassion, respect and dignity, and creates an ethical conflict with the Code of Medical Ethics Opinion E-1.1.7 “Physician Exercise of Conscience”; specifically by:1. Deleting all references to “suicide”, including “Physician-assisted suicide” and replacing such language by referring to “Physician-assisted dying (PAD)”;
2. Deleting language that suggests that PAD is a form of doing harm and is therefore antithetical to the admonition to “do no harm”, such as “assisted suicide would ultimately cause more harm than good”;
3. Deleting language that characterizes PAD as a choice by a patient “that death is preferable to life” and replacing that language with a description of PAD as giving a terminally ill patient the option of being in control of the manner of his or her death, without assigning a value judgment to that option;
4. Deleting language that characterizes PAD as “fundamentally incompatible with the physician’s role as healer”, and instead recognizing that a physician who participates in PAD is doing so as an act of compassion and caring for patients who have no prospect of healing their fatal illness;
5. Delete language that suggests that PAD is not compatible with “responding to the needs of patients at the end of life” or that PAD is “abandonment” (Directive to Take Action); and be it further

RESOLVED, In recognition of the fact that highly ethical physicians may have differing opinions on Physician Assisted Dying (PAD), but also in recognition of our respect for patient autonomy and the growing numbers of patients who wish to exercise choice over the manner of imminent death, that our American Medical Association’s Council on Judicial and Ethical Affairs (CEJA) be strongly encouraged to modify Code of Medical Ethics Opinion E-5.7 “Physicians-Assisted Suicide” to follow the lead of a number of state and national medical societies by adopting the ethical position of “Engaged Neutrality”, defined as neither in favor of nor or in opposition to PAD, while providing reassurance that our AMA will be a resource to lawmakers, physicians and the public to ensure compliance with standards of lawful medical practice, and to protect physicians’ freedom to participate or not participate in PAD in accordance with their personal beliefs and our AMA’s Opinion E-1.1.7 “Physician Exercise of Conscience”. (Directive to Take Action) |
| .Con | Res. 021# | Health, In All Its Dimensions, Is A Basic Human RightConnecticutRESOLVED, That our American Medical Association acknowledge that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right (New HOD Policy); and be it furtherRESOLVED, That the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. (New HOD Policy) |
| .Con | Res. 022# | Opposition to Involuntary Civil Commitment for Substance Use DisorderConnecticutRESOLVED, That our American Medical Association oppose involuntary civil commitment without judicial involvement of persons for reasons solely related to substance-use disorder (New HOD Policy); and be it furtherRESOLVED, That our AMA work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services. (Directive to Take Action) |
| .Con | Res. 023\* | Distribution and Display of Human Trafficking Aid Information in Public PlacesTexasRESOLVED, That our American Medical Association adopt as policy that readily visible signs, notices, posters, placards, and other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings (New HOD Policy); and be it further RESOLVED, That our AMA, through its website or internet presence, provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same (Directive to Take Action); and be it further RESOLVED, That our AMA urge the federal government to make changes in laws to advocate for the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings. (Directive to Take Action) |
| .Con | Res. 024\* | Eliminating Use of the Term “Mental Retardation” by Physicians in Clinical SettingsTexasRESOLVED, That our American Medical Association recommend that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings. (New HOD Policy) |
| .Con | Res. 025\* | Gender Equity in Hospital Medical Staff BylawsOrganized Medical Staff SectionRESOLVED, That our American Medical Association affirm that hospital medical staff bylaws should promote, and not impede, gender equity in their implementation (New HOD Policy); and be it furtherRESOLVED, That our AMA study existing hospital medical staff bylaws as to how they impact on issues of gender equity, directly or indirectly, and suggest any addition(s) to its modelbylaws to assure this issue is properly addressed, and gender equity affirmed. (Directive to Take Action) |
| .Con | Res. 026\* | Restrictive Covenants of Large Health Care SystemsOrganized Medical Staff SectionRESOLVED, That our American Medical Association, through its Organized Medical Staff Section, educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the impact that restrictive covenants have across all practice settings, including but not limited to the effect on patient access to health care, the patient-physician relationship, and physician autonomy, with report back at the 2019 Interim Meeting. (Directive to Take Action) |
| .Con | Res. 027\* | Model Legislation for "Mature Minor" Consent to VaccinationsYoung Physicians SectionRESOLVED, That our American Medical Association support physicians in assessing whether a minor has met maturity and medical decision-making capacity requirements when providing consent for vaccinations and in developing protocols for appropriate documentation (Directive to Take Action); and be it further RESOLVED, That our AMA develop model legislation to aid states in developing their own policies to allow “mature minors”, defined as “certain older minors who have the capacity to give informed consent to do so for care that is within the mainstream of medical practice, not high risk, and provided in a nonnegligent manner,” to self-consent for vaccinations. (Directive to Take Action) |
| A | CMS 02 | Covering the Uninsured under the AMA Proposal for Reform1. That our American Medical Association (AMA) support eliminating the subsidy “cliff”, thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL). (New HOD Policy)2. That our AMA support increasing the generosity of premium tax credits. (New HOD Policy)3. That our AMA support expanding eligibility for cost-sharing reductions. (New HOD Policy)4. That our AMA support increasing the size of cost-sharing reductions. (New HOD Policy)5. That our AMA reaffirm Policy H-165.828, which supports legislation or regulation, whichever is relevant, to fix the Affordable Care Act (ACA’s) “family glitch”; and capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability. (Reaffirm HOD Policy)6. That our AMA reaffirm Policy H-165.842, which supports the establishment of a permanent federal reinsurance program. (Reaffirm HOD Policy)7. That our AMA reaffirm Policy H-165.824, which supports providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; encourages state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; and supports adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits. (Reaffirm HOD Policy)8. That our AMA reaffirm Policy D-290.979, which states that our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent [(138 percent federal poverty level (FPL) including the income disregard)] FPL as authorized by the ACA. (Reaffirm HOD Policy)9. That our AMA reaffirm Policy H-290.965, which supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016. (Reaffirm HOD Policy)10. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support educational and outreach efforts targeted at those eligible for Medicaid and Children’s Health Insurance Program, as well as improved and streamlined enrollment mechanisms for those programs. (Reaffirm HOD Policy)11. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD Policy) |
| A | CMS 03 | Medicare Coverage for Dental Services1. That our American Medical Association (AMA) reaffirm Policy D-160.925, which recognizes the importance of managing oral health, access to dental care as a part of optimal patient care, and collaboration with the American Dental Association (ADA). (Reaffirm HOD Policy)2. That our AMA support continued opportunities to work with the ADA and otherinterested national organizations to improve access to dental care for Medicare beneficiaries. (New HOD Policy)3. That our AMA support initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (New HOD Policy) |
| A | CMS 04 | Reclassification of Complex Rehabilitation Technology1. That our American Medical Association (AMA) support the reclassification of complex rehabilitation technology (CRT) as a separate, distinct, and adequately funded payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs. (New HOD Policy).2. That our AMA support state medical association and national medical specialty society efforts to accomplish adequately funded reclassification of CRT. (New HOD Policy)3. That our AMA support, upon reclassification of CRT as a distinct category, the development by the Centers for Medicare & Medicaid Services of additional requirements and/or regulations specific to CRT, beyond those that exist under the broad category of durable medical equipment. (New HOD Policy) |
| A | CMS 05 | The Impact of Pharmacy Benefit Managers on Patients and Physicians1. That our American Medical Association (AMA) support the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. (New HOD Policy)2. That our AMA develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. (Directive to Take Action)3. That our AMA support requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale. (New HOD Policy)4. That our AMA support efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity. (New HOD Policy)5. That our AMA support improved transparency of PBM operations, including disclosing:- Utilization information;- Rebate and discount information;- Financial incentive information;- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee’s formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and- Percentage of sole source contracts awarded annually. (New HOD Policy)6. That our AMA encourage increased transparency in how DIR fees are determined and calculated. (New HOD Policy)7. That our AMA reaffirm Policy H-125.979, which aims to prohibit drugs from being removed from the formulary or moved to a higher cost tier during the duration of the patient’s plan year. (Reaffirm HOD Policy)8. That our AMA reaffirm Policy H-320.939, which supports efforts to track and quantify the impact of health plans’ prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. (Reaffirm HOD Policy)9. That our AMA reaffirm Policy H-285.965, which outlines AMA policy objectives addressing managed care cost containment involving prescription drugs. (Reaffirm HOD Policy)10. That our AMA reaffirm Policy D-330.910, which states that our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare & Medicaid Services and other appropriate organizations to resolve them. (Reaffirm HOD Policy)11. That our AMA reaffirm Policy H-320.958, which states that our AMA will advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession. (Reaffirm HOD Policy) |
| A | CMS 06 | Preventive Prostate Cancer Screening1. That our American Medical Association (AMA) encourage public and private payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making. (New HOD Policy)2. That our AMA encourage national medical specialty societies to promote public education around the importance of informed physician-patient shared decision-making regarding medical services that are particularly sensitive to patient values and circumstances, such as prostate cancer screening. (New HOD Policy)3. That our AMA amend Policy D-450.957 to change the title to read, “Clinical Guidelines and Evidence Regarding Benefits of Prostate Cancer Screening and Other Preventive Services,” and to add a new subsection, “(3) encouraging scientific research to address the evidence gaps highlighted by organizations making evidence-based recommendations about clinical preventive services.” (Modify Current HOD Policy)4. That our AMA reaffirm Policy D-185.979 regarding aligning clinical and financial incentives for high-value care and highlighting the role national medical specialty societies can play in helping to shape value-based insurance design (VBID) plans that decrease cost-sharing to encourage utilization of high-value services. (Reaffirm HOD Policy)5. That our AMA reaffirm Policy H-185.939 which supports VBID plans that explicitly consider the clinical benefit of a given service when determining cost-sharing structures or other benefit design elements. (Reaffirm HOD Policy)6. That our AMA reaffirm Policy H-373.997, which sets forth core elements of physician-patient shared decision-making and Policy H-450.938, which sets forth the principles to guide physician value-based decision-making, including providing physicians with easy access to costs of care at the point of decision-making. (Reaffirm HOD Policy)7. That our AMA reaffirm Policy D-185.980, which supports coverage for evidence-based genetic/genomic precision medicine and Policy H-425.997, which supports insurance coverage for evidence-based, cost-effective preventive services. (Reaffirm HOD Policy) |
| A | Res. 101  | Health Hazards of High Deductible InsuranceIndianaRESOLVED, That our American Medical Association support health insurance deductibles of not more than $1,000 for an individual per year, especially to patients with significant chronic disease. (New HOD Policy) |
| A | Res. 102 | Use of HSAs for Direct Primary CareIlliniosRESOLVED, That our American Medical Association adopt policy that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense (New HOD Policy); and be it furtherRESOLVED, That our AMA seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use Health Savings Accounts (HSAs) to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty. (Directive to Take Action) |
| A | Res. 103 | Health System Improvement StandardsNew YorkRESOLVED, That our American Medical Association advocate for health care reform proposals that would achieve the following:- Reduce the number of uninsured; and- Reduce barriers to insured patients receiving needed health care, including ensuring full transparency of patient-cost sharing requirements, preventing unjustified denials of coverage, ensuring comprehensive physician networks, including through fair reimbursement methodologies, and providing meaningful coverage for out-of-network care; and- Reduce administrative burden on physicians; and- Prevent imposition of new costs or unfunded mandates on physicians; and- Provide needed tort reform; and- Provide meaningful collective negotiation rights for physicians. (Directive to Take Action) |
| A | Res. 104 | Adverse Impacts of Single Specialty Independent Practice AssociationsNew YorkRESOLVED, That our American Medical Association conduct a study relating to the impact of managed care plans replacing their participating physicians with those of a non-primary care physician single specialty independent practice association. (Directive to Take Action) |
| A | Res. 105 | Payment for Brand Medications When the Generic Medication is RecalledNew YorkRESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services as well as third party payers to allow reimbursement for brand medications at the lowest copayment tier so that patients can be effectively treated until the medication manufacturing crisis is resolved. (Directive to Take Action) |
| A | Res. 106 | Raising Medicare Rates for PhysiciansNew YorkRESOLVED, That our American Medical Association advocate strongly for raising the Medicare Fee Schedules for physicians. (Directive to Take Action) |
| A | Res. 107 | Investigate Medicare Part D – Insurance Company UpchargeOhioRESOLVED, That our American Medical Association investigate Medicare Part D rules which allow providers to keep up to 5% more than their actual cost of providing pharmacy prescription services while at the same time they are eligible to get paid by Centers for Medicare and Medicaid Services reinsurance rules for certain losses. (Directive to Take Action) |
| A | Res. 108 | Congressional Healthcare ProposalsOhioRESOLVED, That our American Medical Association support provisions in Federal legislation that:1. Do not limit the choices available for Americans for health care coverage2. Support improving existing health plans3. Make any new plan voluntary4. Do not eliminate the private insurance market. (Directive to Take Action) |
| A | Res. 109 | Part A Medicare Payment to PhysiciansOhioRESOLVED, That our American Medical Association work for enactment of legislation to direct cash payments from Part A Medicare to physicians in direct proportion to demonstrated savings that are made in Part A Medicare through the efforts of physicians. (Directive to Take Action) |
| A | Res. 110 | Establishing Fair Medicare Payer RatesOhioRESOLVED, That our American Medical Association pursue Centers for Medicare and Medicaid Services (CMS) intervention and direction to prevent commercial Medicare payers from compensating physicians at rates below Medicare’s established rates. (Directive to Take Action) |
| A | Res. 111 | Practice Overhead Expense and the Site-of-Service DifferentialOhioRESOLVED, That our American Medical Association appeal to the US Congress for legislation to direct the Centers for Medicare and Medicaid Services (CMS) to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor’s office (Directive to Take Action); and be it furtherRESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that can safely be performed in a doctor’s office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense (Directive to Take Action); and be it furtherRESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. (Directive to Take Action)  |
| A | Res. 112 | Health Care Fee TransparencyOhioRESOLVED, That our American Medical Association advocate for federal legislation and/or regulation to require disclosure of hospital prices negotiated with insurance companies in effort to achieve third-party contract transparency (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for federal legislation and/or regulation to require pharmaceutical companies to disclose drug prices in their television (TV) ads in order to provide consumers more choice and control over their healthcare. (Directive to Take Action) |
| A | Res. 113 | Ensuring Access to Statewide Commercial Health PlansWashingtonRESOLVED, That our American Medical Association study the concept of offering state employee health plans to every state resident, including exchange participants qualifying for federal subsidies, and report back to the House of Delegates this year (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate that State Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity. (New HOD Policy) |
| A | Res. 114 | Ensuring Access to Nationwide Commercial Health PlansWashingtonRESOLVED, That our American Medical Association advocate that Federal Employees Health Benefits Program health insurance plans should become available to everyone to purchase at actuarially appropriate premiums as well as be eligible for federal premium tax credits (New HOD Policy); and be it furtherRESOLVED, That our AMA advocate that Federal Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity. (New HOD Policy) |
| A | Res. 115 | Safety of Drugs Approved by Other CountriesWisconsinRESOLVED, That our American Medical Association compare the results of our US Food and Drug Administration (FDA) and the European Medicines Agency (EMA) approval processes in terms of determining the safety and efficacy of pharmaceuticals using whatever data is available in order to determine whether the health of the citizens of the United States would be at risk if drugs approved by the EMA were imported and used as compared to the FDA (Directive to Take Action); and be it furtherRESOLVED, That our AMA estimate what the reduction in the cost of medications would be for our patients if they were allowed to import EMA certified medications for use in the United States and thereby increasing competition for some of our current expensive pharmaceuticals. (Directive to Take Action) |
| A | Res. 116 | Medicare for AllWisconsinRESOLVED, That our American Medical Association gather current, accurate data on the reimbursement from Medicare for private practice physicians, medical clinics, hospital outpatient services, hospitals including rural hospitals and critical access hospitals, and healthcare systems along with accurate data as to how the reimbursement compares to the cost for providing the medical care for these services (Directive to Take Action); and be it furtherRESOLVED, That our AMA evaluate what would happen to the healthcare economics of the United States and the ability to continue outpatient medical practice if the current Medicare reimbursement, compared to the cost of providing that care, became the major financing resource for medical care and predict what effect this would have on the access to medical care in the U.S. (Directive to Take Action); and be it furtherRESOLVED, That our AMA evaluate how the current differential payments in Medicare to various entities for the same service would change in a “ Medicare for all” scenario (Directive to Take Action); and be it furtherRESOLVED, That our AMA, after analysis of the data, provide to the patients and physicians of our country the relevant questions that we can ask of political candidates advocating “Medicare for all” and (Directive to Take Action); and be it furtherRESOLVED, That our AMA provide a better understanding of the impact of “Medicare for all” in terms of healthcare financing, workforce, ability to continue private practice medical care, incentives for physicians to join hospital systems, availability of care, and help understand how this might change the provision of healthcare in the United States. (Directive to Take Action) |
| A | Res. 117 | Support for Medicare Disability Coverage of Contraception for Non-Contraceptive UseResident and Fellow SectionRESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and other stakeholders to include coverage for all US Food and Drug Administration -approved contraception for non-contraceptive use for patients covered by Medicare. (Directive to Take Action) |
| A | Res. 118 | Pharmaceutical Pricing TransparencyOklahomaRESOLVED, That our American Medical Association lobby for legislation that requires Pharmacy Benefit Managers to enhance drug-pricing transparency for the benefit of patients. (Directive to Take Action) |
| A | Res. 119# | Returning Liquid Oxygen to Fee Schedule PaymentAmerican Thoracic SocietyRESOLVED, That our American Medical Association support policy to remove liquid oxygen from the competitive bidding system and return payments for liquid oxygen to a Medicare fee schedule basis (New HOD Policy); and be it furtherRESOLVED, That our AMA convey its patient quality and access concerns for Medicare beneficiaries obtaining insurance coverage for liquid oxygen in comments to the Centers for Medicare and Medicaid Services, including the forthcoming proposed rule, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) for Calendar Year 2020. (Directive to Take Action) |
| A | Res. 120# | Medicare Coverage of Hearing AidsGeorgiaRESOLVED, That our American Medical Association urge Medicare to cover some or all of the costs of a "reasonable" device for both ears if a patient has had an audiological exam that identifies the need, and for Medicare to identify a vendor, or vendors of hearing devices that produce a quality product without an exorbitant retail price. (Directive to Take Action) |
| A | Res. 121# | Maintenance Hemodialysis for Undocumented PersonsMichiganRESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to identify and advocate for equitable health care options to provide scheduled maintenance hemodialysis to undocumented persons. (Directive to Take Action) |
| A | Res. 122# | Reimbursement for Telemedicine VisitsMichiganRESOLVED, That our American Medical Association work with third-party payers and the Centers for Medicare and Medicaid Services at the national level to provide reimbursement for both synchronous and asynchronous telemedicine services to encourage increased access and use of these services by patients and physicians. (Directive to Take Action |
| A | Res. 123# | Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum DisorderMedical Student SectionRESOLVED, That our American Medical Association support the coverage and reimbursement for Applied Behavioral Analysis for the purpose of treating Autism Spectrum Disorder. (Directive to Take Action) |
| A | Res. 124# | Increased Affordability and Access to Hearing Aids and Related CareMedical Student SectionRESOLVED, That our American Medical Association support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly (New HOD Policy); and be it furtherRESOLVED, That our AMA encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids (New HOD Policy); and be it further RESOLVED, That our AMA support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss. (New HOD Policy) |
| A | Res. 125# | Mitigating the Negative Effects of High-Deductible Health PlansConnecticutRESOLVED, That our American Medical Association advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments. (Directive to Take Action) |
| A | Res. 126# | Ensuring Prescription Drug Price Transparency from Retail PharmaciesConnecticutRESOLVED, That our American Medical Association amend policy H-110.991, “Price of Medicine,” by addition and deletion as follows:Our AMA:(1) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare’s drug-pricing dashboard; ~~(1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications;~~ (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies’ contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient’s co-pay is higher than the drug’s cash price; (4) will disseminate model state legislation to promote drug price and cost transparency ~~and to prohibit “clawbacks” and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication~~; and (5) supports physician education regarding drug price and cost transparency, manufacturers’ pricing practices, and challenges patients may encounter at the pharmacy point-of-sale. (Modify Current HOD Policy) |
| A | Res. 127# | Eliminating the CMS Observation StatusNew JerseyRESOLVED, That our American Medical Association request, for the benefit of our patients’ financial, physical and mental health, that the Centers for Medicare and Medicaid Services terminate the “48 hour observation period” and observation status in total. (Directive to Take Action) |
| A | Res. 128\* | Elimination of CMS Hospital Readmission PenaltiesNew JerseyRESOLVED, That our American Medical Association immediately write a letter to the Centers for Medicare and Medicaid Services and Congress with the goal of working together to remove the financial penalty for any cause readmissions to a hospital (Directive to Take Action); and be it furtherRESOLVED, That our AMA reaffirm policy H-340.989, “PRO Readmission Review.” (Reaffirm HOD Policy) |
| A | Res. 129\* | The Benefits of Importation of International Pharmaceutical MedicationsTexasRESOLVED, That our American Medical Association study the implications of prescription drug importation for personal use and wholesale prescription drug purchase across our southern and northern borders. (Directive to Take Action) |
| A | Res. 130\* | Notification of Generic Drug Manufacturing ChangesTexasRESOLVED, That our American Medical Association lobby Congress to pass legislation that ensures that each patient is expressly notified at the time of dispensing by the pharmacy or pharmacy benefit manager of a change in the manufacturer of his or her generic medication. (Directive to Take Action) |
| A | Res. 131\* | Update Practice Expense Component of Relative Value UnitsTexasRESOLVED, That our American Medical Association pursue efforts to update resource-based relative value unit practice expense methodology so it accurately reflects current physician practice costs, with a report back at the AMA House of Delegates 2019 Interim Meeting. (Directive to Take Action) |
| B | BOT 09 | Council on Legislation Sunset Review of 2009 House PoliciesIn this report, the Board of Trustees presents the Council on Legislation’s recommendations on the disposition of the House policies that were assigned to it. The Council on Legislation’s recommendations on policies are presented in the Appendix to this report. |
| B | BOT 14 | Reforming the Orphan Drug Act; An Optional National Prescription Drug Formulary; Reform of Pharmaceutical Pricing: Negotiated Payment Schedules1. That our AMA reaffirm Policy H-110.987, “Pharmaceutical Costs,” which outlines a series of measures to address anti-competitive actions by pharmaceutical manufacturers as well as policies to promote increased transparency along the pharmaceutical supply chain including among PBMs. (Reaffirm HOD Policy)2. That our AMA support legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations. (New HOD Policy) |
| B | BOT 17 | Ban on Medicare Advantage “No Cause” Network Terminations1. That our American Medical Association (AMA) urge Centers for Medicare & Medicaid Services (CMS) to further enhance the agency’s efforts to ensure directory accuracy by:a. Requiring MA plans to submit provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network.b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies.c. Publicly reporting the most recent accuracy score for each plan on [Medicare Plan Finder](https://www.medicare.gov/find-a-plan/%28X%281%29S%28yetxywjxl3wsvhqqyfa3y1wr%29%29/questions/search-by-plan-name-or-plan-id.aspx?AspxAutoDetectCookieSupport=1).d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following: 1. civil monetary penalties; 2. enrollment sanctions; or 3. incorporating the accuracy score into the Stars rating for each plan.e. Offering plans the option of using [AMA/Lexis-Nexis VerifyHCP](https://www.ama-assn.org/delivering-care/patient-support-advocacy/verifyhcp) system to update provider directory information. (Directive to Take Action)2. That our AMA urge CMSto ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by:a. Requiring plans to report the percentage of the physicians in the network who actually provided services to plan members during the prior year.b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy.c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together.d. Evaluating alternative/additional measures of adequacy. (Directive to Take Action)3. That our AMA urge CMSto ensure lists of contracted physicians are made more easily accessible by:a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form. (Directive to Take Action)b. Linking the provider lists to [Physician Compare](https://www.medicare.gov/physiciancompare/) so that a patient can first find a physician and then find which health plans contract with that physician. That our AMA urge CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: A. the number of contracted physicians in each specialty and county; B. the extent to which a plan's network exceeds minimum standards in each specialty and county; and C. the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan’s network. (Directive to Take Action)4. That our AMA urge CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty in an MA plan’s network compared to the previous year and over several years and post that information on Plan Finder. (Directive to Take Action)5. That our AMA urge CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website. (Directive to Take Action)6. That our AMA urge CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force. (Directive to Take Action)7. That our AMA rescind Policy D-285.961, which directed the AMA to conduct the study herein. (Rescind AMA Policy) |
| B | BOT 18 | Increased Use of Body-Worn Cameras by Law Enforcement Officers1. That our American Medical Association (AMA) work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase body-worn cameras, training for officers and technical assistance for law enforcement agencies. (Directive to Take Action);2. That our AMA continue to monitor privacy issues raised by body-worn cameras in health care settings. (Directive to Take Action); and3. That our AMA recommend that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from the medical community and not interfere with the patient-physician relationship. (Directive to Take Action) |
| B | BOT 19 | FDA Conflict of Interest1. That our AMA reaffirm Policy H-100.992, “FDA,” which supports that FDA conflicts of interest should not overrule scientific evidence in making policy decisions and the FDA should include clinical experts on advisory committees. (Reaffirm HOD Policy)2. That our AMA adopt the following new policy:It is the position of the American Medical Association that decisions of the Food and Drug Administration (FDA) must be trustworthy. Patients, the public, physicians, other health care professionals and health administrators, and policymakers must have confidence that FDA decisions and the recommendations of FDA advisory committees are ethically and scientifically credible and derived through a process that is rigorous, independent, transparent, and accountable. Rigorous policies and procedures should be in place to minimize the potential for financial or other interests to influence the process at all key steps. These should include, but not necessarily be limited to: a) required disclosure of all relevant actual or potential conflicts of interest, both financial and personal; b) a mechanism to independently audit disclosures when warranted; c) clearly defined criteria for identifying and assessing the magnitude and materiality of conflicts of interest; and d) clearly defined processes for preventing or terminating the participation of a conflicted member, and mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when an individual’s participation cannot be terminated due to the individual’s unique or rare skillset or background that is deemed highly valuable to the process. Further, clear statements of COI policy and procedures, and disclosures of FDA advisory committee members’ conflicts of interest relating to specific recommendations, should be published or otherwise made public. Finally, it is recognized that, to the extent feasible in accordance with the principles stated above, participation on advisory committees should be facilitated through appropriate balancing of the relative scarcity or uniqueness of an individual’s expertise and ability to contribute to the process, on the one hand, as compared to the feasibility and effectiveness of mitigation measures including those noted above. (New HOD Policy)3. That our AMA adopt the following new policy:It is the position of the American Medical Association that the FDA should undertake an evaluation of pay-later conflicts of interest (e.g., where a FDA advisory committee member develops a financial conflict of interest only after his or her initial appointment on the advisory committee has expired) to assess whether these undermine the independence of advisory committee member recommendations and whether policies should be adopted to address this issue. (New HOD Policy) |
| B | BOT 20 | Safe and Efficient e-Prescribing1. That our American Medical Association (AMA) reaffirm the following policies:a. H-125.979, “Private Health Insurance Formulary Transparency”b. D-120.956, “Electronic Prescribing and Conflicting Federal Guidelines”c. H-120.941, “e-Prescribing of Scheduled Medications”d. D-120.958, “Federal Roadblocks to E-Prescribing”e. D-120.945. “Completing the Electronic Prescription Loop for Controlled Substances” (Reaffirm HOD Policy)2. That the second paragraph of AMA Policy D-120.972, “Electronic Prescribing,” be rescinded as having been fulfilled by this report. (Rescind HOD Policy)3. That our AMA encourage health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:- E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.- Health care organizations and implementation teams to improve prescriber end-user training and on-going education.- Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues.- Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.- Organizational leadership to encourage the practice of inputting a patient’s preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.- Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.- Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician.- Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.- Organizational leadership to designate e-prescribing as the default prescription method.- The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.- States to allow integration of PDMP data into EHR systems.- Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy’s network status. (New HOD Policy) |
| B | BOT 21 | Augmented Intelligence (AI) in Health CareOur AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) clinical evidence.4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.8. Our AMA, national medical specialty societies, and state medical associations—a. Identify areas of medical practice where AI systems would advance the quadruple aim;b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;c. Outline new professional roles and capacities required to aid and guide health care AI systems; andd. Develop practice guidelines for clinical applications of AI systems.9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy) |
| B | BOT 22 | Inappropriate Use of CDC Guidelines for Prescribing Opioids1. That our American Medical Association (AMA) support balanced opioid-sparing policies that are not based on hard thresholds, but on patient individuality, and help ensure safe prescribing practices, minimize workflow disruption, and ensure patients have access to their medications in a timely manner, without additional, cumbersome documentation requirements. (New HOD Policy)2. That our AMA oppose the use of “high prescriber” lists used by national pharmacy chains, pharmacy benefit management companies or health insurance companies when those lists do not provide due process and are used to blacklist physicians from writing prescriptions for controlled substances and preventing patients from having the prescription filled at their pharmacy of choice. (New HOD Policy) |
| B | BOT 23 | Prior Authorization Requirements for Post-Operative OpioidsThe Board recommends that the following recommendation be adopted in lieu of Resolution 208-A-18, and that the remainder of the report be filed.1. That our American Medical Association (AMA) advocate for state legislatures and other policymakers, health insurance companies and pharmaceutical benefit management companies to remove barriers, including prior authorization, to non-opioid pain care. (New HOD Policy)2. That our AMA support amendments to opioid restriction policies to allow for exceptions that enable physicians, when medically necessary in the physician’s judgment, to exceed statutory, regulatory or other thresholds for post-operative care and other medical procedures or conditions. (New HOD Policy)3. That our AMA oppose health insurance company and pharmacy benefit management company utilization management policies, including prior authorization, that restrict access to post-operative pain care, including opioid analgesics, if those policies are not based upon sound clinical evidence, data and emerging research. (New HOD Policy) |
| B | BOT 30 | Opioid Treatment Programs Reporting to Prescription Monitoring ProgramsThe Board of Trustees recommends that Resolution 507-A-18 not be adopted and the remainder of this report be filed. |
| B | Res. 201 | Assuring Patient Access to Kidney TransplantationAmerican Society of Transplant SurgeonsRESOLVED, That our American Medical Association work with professional and patient-centered organizations to advance patient and physician-directed coordinated care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it furtherRESOLVED, That our AMA actively oppose any legislative or regulatory efforts to remove patient choice and physician involvement in ESRD care decisions (Directive to Take Action); and be it furtherRESOLVED, That our AMA actively oppose any legislative or regulatory effort that would create financial incentives that would curtail the access to organ transplantation (Directive to Take Action); and be it furtherRESOLVED, That our AMA House of Delegates be advised in a timely fashion regarding any legislative or regulatory efforts to abrogate patient and physician-advised decision-making regarding modality of care for ESRD. (Directive to Take Action) |
| B | Res. 202 | Reducing the Hassle Factor in Quality Improvement ProgramsCaliforniaRESOLVED, That our American Medical Association recommend to the Centers for Medicare and Medicaid Services (CMS) and physician certifying boards, such as the American Board of Medical Specialties, that maintenance of certification (MOC) participation count toward satisfying the quality category of the Merit-Based Incentive Payment Program (MIPS) (Directive to Take Action); and be it furtherRESOLVED, That our American Medical Association also recommend that successful reporting in the quality category of the Merit-Based Incentive Payment Program (MIPS) count toward satisfying the practice performance assessment section of a certifying board’s MOC requirements) (Directive to Take Action); and be it furtherRESOLVED, That our AMA study MOC and Medicare MIPS reciprocity and work with the state and national specialty societies to develop a plan to reduce quality measure duplication and administrative burdens in both the MIPS and MOC programs. (Directive to Take Action) |
| B | Res. 203 | Medicare Part B and Part D Drug Price NegotiationCaliforniaRESOLVED, That our American Medical Association advocate for Medicare to cover all physician-recommended adult vaccines in both the Medicare Part D and the Medicare Part B programs (Directive to Take Action); and be it furtherRESOLVED, That our AMA make it a priority to advocate for a mandate on pharmaceutical manufacturers to negotiate drug prices with the Centers for Medicare and Medicaid Services for Medicare Part D and Part B covered drugs (Directive to Take Action); and be it furtherRESOLVED, That our AMA explore all options with the state and national specialty societies to ensure that physicians have access to reasonable drug prices for the acquisition of Medicare Part B physician-administered drugs and that Medicare reimburse physicians for their actual drug acquisition costs, plus appropriate fees for storage, handling, and administration of the medications, to ensure access to high-quality, cost-effective care in a physician’s office. (Directive to Take Action) |
| B | Res. 204 | Holding the Pharmaceutical Industry Accountable for Opioid-Related CostsCaliforniaRESOLVED, That our American Medical Association advocate that the relevant pharmaceutical industry organizations be held financially responsible for the health care and other economic costs related to their unethical and deceptive misbranding, marketing, and advocacy of opioids. (Directive to Take Action) |
| B | Res. 205 | Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician SalaryIllinoisRESOLVED, That our American Medical Association adopt policy opposing any association between anonymous patient satisfaction scores (e.g. “loyalty scores”) or the coworkers’ observation reporting system, and employed physicians’ salaries (New HOD Policy); and be it furtherRESOLVED, That our AMA adopt policy opposing any publication of anonymous patient satisfaction scores or coworkers’ observation reporting system information directed at an individual physician (New HOD Policy); and be it furtherRESOLVED, That our AMA adopt policy opposing the use of any anonymous patient satisfaction scores or any individually and anonymously posted patient or co-worker comments in formulating or impacting employed physician salaries or in relation to any other physician compensation program. (New HOD Policy) |
| B | Res. 206 | Changing the Paradigm: Opposing Present and Obvious Restraint of TradeIllinoisRESOLVED, That our American Medical Association seek legislative or regulatory changes to allow physicians to collectively negotiate professional fees, compensation and contract terms without integration. (Directive to Take Action) |
| B | Res. 207 | Direct-to-Consumer Genetic TestsIllinoisRESOLVED, That our American Medical Association regard research using consumer genome data derived from saliva or cheek swab samples as research on human subjects requiring consents in compliance with the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an “opt in” option to allow more consumer choice in the consent process (Directive to Take Action); and be it furtherRESOLVED, That our AMA amend Policy H-315.983, “Patient Privacy and Confidentiality,” by addition to align with current research and privacy infringement findings, as follows:1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received, while working with the Department of Health and Human Services (HHS) to stop the transfer of birthdates and state of residence by genetic testing companies and their affiliates, unless there is explicit user approval, to prevent re-identification of the test user by way of surname inference methods.2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Wheher they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. Our AMA regards studies using consumer genome data derived from saliva, cheek swab, or other human tissue samples as research on human subjects requiring consents in compliance with the HHS Office for Human Research Protections (OHRP). An “opt in” option is recommended to allow more consumer choice in the consent process.8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. The AMA will work with Congress and HHS to modify the Genetic Information Nondiscrimination Act of 2008 (GINA), which bans genome-based policy and hiring decisions by health insurance companies and employers, by adding Long-Term Care, Life Insurance, and Disability Insurance to the Act to prevent applicant rejection based on their genetic make up.18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.a. Our AMA supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identified information with other parties without the consent of the user. An exception would be made when requested by law enforcement authorities or when keeping the information would seriously threaten their health or that of others. If a data security breach occurs with the Direct-To –Consumer genetic company or its collaborators, then the company has the responsibility to inform all users of the breach and the impact of the unprotected private data on those individuals;19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA work with the Department of Health and Human Services or other relevant parties to modify the rules to prevent genetic testing entities from transferring information about the user’s date of birth and state of residence to third parties which may result in the re-identification of the user based on surname inference (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with Congress and the Department of Health and Human Services to extend the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California. (Directive to Take Action) |
| B | Res. 208 | Repeal or Modification of the Sunshine ActIllinoisRESOLVED, That our American Medical Association adopt as policy opposition to the Physician Payments Sunshine Act as it currently is written and implemented (New HOD Policy); and be it furtherRESOLVED, That our AMA support either repeal of the current Sunshine Act or significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the burden and “hassle factor” and support efforts at administrative simplification for physicians, which the Center for Medicare and Medicaid Services and the organized medical community has supported, if any portion of the Act is maintained. (New HOD Policy) |
| B | Res. 209 | Mandates by ACOs Regarding Specific EMR UseIllinoisRESOLVED, That our American Medical Association adopt policy stating that Accountable Care Organizations cannot mandate their membership to use a single specific Electronic Medical Record (EMR) (New HOD Policy); and be it furtherRESOLVED, That our AMA move to effect legislation that prevents Accountable Care Organizations from imposing EMR mandates. (Directive to Take Action) |
| B | Res. 210 | Air AmbulancesNew YorkRESOLVED, That our American Medical Association support federal legislation which would:1. Establish an expedited independent dispute resolution system to resolve payment disputes between emergency air ambulance providers and health insurers; and2. Ensure that such independent dispute resolution process would ensure the patient be “held harmless” except for applicable insurance policy in-network cost-sharing requirements. (New HOD Policy) |
| B | Res. 211 | Use of FAIR HealthNew YorkRESOLVED, That our American Medical Association advocate that any legislation addressing surprise out of network medical bills use FAIR Health usual and customary data and not all payer database data. (Directive to Take Action) |
| B | Res. 212 | Pharmacy Benefit ManagersNew YorkRESOLVED, That our American Medical Association advocate through all appropriate means to ensure that medications used to stabilize palliative and hospice patients for pain and delirium in the hospital continue to be covered by pharmacy benefit plans after patients are transitioned out of the hospital. (Directive to Take Action) |
| B | Res. 213 | Financial Penalties and Clinical Decision-MakingNew YorkRESOLVED, That our American Medical Association oppose the practice of a payer utilizing statistical targets alone (and not outcomes data) to determine ‘cost effectiveness’ of a therapeutic choice (New HOD Policy); and be it furtherRESOLVED, That our AMA oppose the practice of a payer imposing financial penalties upon physicians and/or associated physicians based upon the use of statistical targets without first considering the clinical factors unique to each patient’s claim. (New HOD Policy) |
| B | Res. 214 | The Term PhysicianNew YorkRESOLVED, That our American Medical Association seek the passage of federal regulation and/or legislation that mandates that the term physician be limited to those people trained in accordance with Accreditation Council for Graduate Medical Education guidelines and have an MD, DO or a recognized equivalent physician degree and that the term not be used by any other organization or person involved in healthcare. (Directive to Take Action) |
| B | Res. 215 | Reimbursement for Health Information TechnologyNew YorkRESOLVED, That our American Medical Association seek the passage of federal regulation and/or legislation that mandates that third party payers allow physician practices to charge a technology fee equal to the copayment of the patient's plan. (Directive to Take Action) |
| B | Res. 216 | Eliminate the Word “Provider” from Healthcare ContractsNew YorkRESOLVED, That our American Medical Association seek legislation to ensure that all references to physicians in government and insurance contracts, agreements, published descriptions, and printed articles eliminate the word “provider” and substitute the accurate and proper term “physician”. (Directive to Take Action) |
| B | Res. 217 | Medicare Vaccine BillingNew YorkRESOLVED, That our American Medical Association advocate that a physician’s office can bill Medicare for all vaccines and that the patient shall only pay the applicable copay to prevent fragmentation of care. (Directive to Take Action) |
| B | Res. 218 | Payment for Medications Used Off Label for Treatment of PainNew YorkRESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services to allow reimbursement for off label use of medications like gabapentin or lidocaine patches at the lowest copayment tier for the indication of pain so that patients can be effectively treated for pain and decrease the number of opioid prescriptions written. (Directive to Take Action) |
| B | Res. 219 | Medical Marijuana License SafetyOklahomaRESOLVED, That our American Medical Association draft model state legislation to amend states’ prescription drug monitoring programs to include a medical marijuana license registry. (Directive to Take Action) |
| B | Res. 220 | Study of Confidentially and Privacy Protection in the Treatment of Substance DisordersPennsylvaniaRESOLVED, That our American Medical Association study whether the confidentiality protections of 42 CFR Part 2 outweigh the potential benefits of coordinating care with HIPAA privacy protections in the treatment of substance related disorders. (Directive to Take Action) |
| B | Res. 221 | Extending Medicaid Coverage to 12-Months PostpartumAmerican College of Obstetricians and GynecologistsRESOLVED That our American Medical Association support and actively work toward enactment of state legislation, Section 1115 waiver applications, and federal legislation to extend Medicaid coverage to 12-months postpartum. (Directive to Take Action) |
| B | Res. 222 | Protecting Patients from Misleading and Potentially Harmful "Bad Drug" AdsKentuckyRESOLVED, That our American Medical Association encourage state legislatures to consider and adopt legislation that helps protect patient health by creating fair rules and regulations around attorney advertisements that:1. Prohibit misuse of governmental logos or the term “recall”2. Provide clear warning of the dangers in stopping a course of treatment without consulting with a physician and3. Require written consent before sharing personal health information. (Directive to Take Action) |
| B | Res. 223 | Simplification and Clarification of Smoking Status Documentation in the Electronic Health RecordWisconsinRESOLVED, That our American Medical Association support the streamlining of the SNOMED categories for smoking status and passive smoking exposure documentation in the electronic medical record so that the categories are discrete, non-overlapping, and better understood per The Association for the Treatment of Tobacco Use and Dependence 2019 recommendations as follows:**Smoking status categories:** Current Every Day Smoker, Current Some Day Smoker Former Smoker, Never Smoker, and Smoking Status Unknown**Passive smoking exposure:** Exposure to Second Hand Tobacco Smoke, Past Exposure to Second Hand Tobacco Smoke, No Known Exposure to Second Hand Tobacco Smoke (Directive to Take Action) |
| B | Res. 224 | Extending Pregnancy Medicaid to One Year PostpartumResident and Fellow SectionRESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services to extend pregnancy Medicaid to a minimum of one year postpartum. (Directive to Take Action) |
| B | Res. 225 | DACA in GMEResident and Fellow SectionRESOLVED, That American Medical Association Policy D-255.991, “Visa Complications for IMGs in GME,” be reaffirmed (Reaffirm HOD Policy); and be it furtherRESOLVED, That AMA Policy D-350.986, “Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages,” be reaffirmed. (Reaffirm HOD Policy) |
| B | Res. 226 | Physician Access to their Medical and Billing RecordsNew YorkRESOLVED, That our American Medical Association advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination (Directive to Take Action); and be it furtherRESOLVED, That our AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician’s access to the medical and billing records such as treating these records as trade secrets or proprietary. (Directive to Take Action) |
| B | Res. 227 | Controlled Substance ManagementAlabamaRESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services (CMS) and interested physician groups to strongly advocate for a mechanism by which physicians may be compensated for controlled substance management (Directive to Take Action); and be it furtherRESOLVED, That our AMA strongly encourage CMS and private payers to recognize and establish equitable payment for controlled substance management. (Directive to Take Action) |
| B | Res. 228 | Truth in AdvertisingAmerican Society of AnesthesiologistsRESOLVED, That our American Medical Association reaffirm support of the Scope of Practice Partnership’s Truth in Advertising Campaign to ensure patients receive accurate information about who is providing their care (AMA Policy H-405.969) (Reaffirm HOD Policy); and be it furtherRESOLVED, That our AMA oppose any misappropriation of medical specialties’ titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers’ state issued licenses and national board certification. (Directive to Take Action) |
| B | Res. 229 | Clarification of CDC Opioid Prescribing GuidelinesAmerican Society of Clinical OncologyRESOLVED, That our American Medical Association reaffirm Policy D-120.932, “Inappropriate Use of Centers for Disease Control and Prevention Guidelines for Prescribing Opioids”; (Reaffirm HOD Policy) and be it furtherRESOLVED, That our AMA incorporate into their advocacy that clinical practice guidelines specific to cancer treatment, palliative care, and end of life be utilized in lieu of the CDC’s Guideline for Prescribing Opioids for Chronic Pain as per the CDC's clarifying recommendation. (Directive to Take Action) |
| B | Res. 230# | State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic AthletesAmerican College of CardiologyRESOLVED, That our American Medical Association and state and specialty medical societies oppose legislation mandating echocardiograms or ECGs as a condition of participation in scholastic sports. (Directive to Take Action) |
| B | Res. 231# | Alignment of Federal Privacy Law and Regulations Governing Substance Use Disorder Treatment (42 CFR Part 2) with the Health Insurance Portability and Accountability ActAmerican Psychiatric AssociationRESOLVED, That our American Medical Association support the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of “Part 2” substance use disorder records in criminal proceedings (New HOD Policy); and be it furtherRESOLVED, That our AMA support the sharing of substance use disorder patient records as required by the HIPAA Privacy Rule for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care. (New HOD Policy) |
| B | Res. 232# | COPD National Action PlanAmerican Thoracic SocietyRESOLVED, That our American Medical Association support the inclusion of $25 million at NIH’s National Heart, Lung, and Blood Institute (NHLBI) and an additional $2 million at the Centers for Disease Control and Prevention in the FY2020 Labor Health and Human Services and Education Appropriations bill to implement the Chronic Obstructive Pulmonary Disease (COPD) National Action Plan (Directive to Take Action); and be it furtherRESOLVED, That our AMA send a letter to House and Senate Appropriators conveying its support for the COPD National Action Plan funding for fiscal year 2020. (Directive to Take Action) |
| B | Res. 233# | GME Cap FlexibilityGeorgiaRESOLVED, That our American Medical Association advocate for Centers for Medicare and Medicaid Services (CMS) to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to primary care residencies (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for CMS to provide funding to hospitals and/or universities prior to the arrival of any residents, removing the clause where “Medicare funding does not begin until the first resident is ‘on-duty’ at the hospital.” (Directive to Take Action) |
| B | Res. 234# | Improved Access to Non-Opioid TherapiesMichiganRESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to improve access to non-opioid treatment modalities including, but not limited to, physical therapy and occupational therapy as recommended by the patient’s physician. (Directive to Take Action) |
| B | Res. 235# | Prescription Coverage of the Lidocaine Transdermal PatchMichiganRESOLVED, That our American Medical Association encourage the United States Food and Drug Administration to consider approving other indications in addition to post-herpetic neuralgia for transdermal lidocaine patches (Directive to Take Action); and be it furtherRESOLVED, That our American Medical Association urge the Centers for Medicare and Medicaid Services and third-party payers to provide insurance coverage of lidocaine transdermal patches for other indications in addition to post-herpetic neuralgia. (Directive to Take Action) |
| B | Res. 236# | Support for Universal Basic Income Pilot StudiesMedical Student SectionRESOLVED, That our American Medical Association support federal, state, local, and/or private Universal Basic Income pilot studies in the United States which intend to measure health outcomes and access to care for participants. (New HOD Policy) |
| B | Res. 237# | Opportunities in Blockchain for HealthcareMedical Student SectionRESOLVED, That our American Medical Association work with the Office of the National Health Information Technology to create official standards for the development and implementation of blockchain technologies in healthcare (Directive to Take Action); and be it furtherRESOLVED, That our AMA monitor the evolution of blockchain technologies in healthcare and engage in discussion with appropriate stakeholders regarding blockchain development. (Directive to Take Action) |
| B | Res. 238# | Coverage Limitations and Non-coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health CrisisNorth American Neuromodulation SocietyRESOLVED, That our American Medical Association support coverage of sacroiliac joint blocks and radiofrequency ablation, facet (spine joint) medial branch blocks and radiofrequency ablation, genicular blocks and radiofrequency ablation for non-operable knee arthritis or pain, femoral and obturator nerve blocks and radiofrequency ablations for non-operable hip arthritis or pain, suprascapular nerve blocks and radiofrequency ablations for non-operable shoulder arthritis or pain, and other arbitrarily limited non-covered interventional pain management procedures, by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans (Directive to Take Action), and be it furtherRESOLVED, That our AMA support coverage of spinal cord stimulation trials and implantation, and peripheral nerve stimulation trials and implantation by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans by ICD-10 codes that have been linked to the respective Current Procedural Terminology (CPT) code set as outlined in the AMA CPT Manual. (Directive to Take Action) |
| B | Res. 239# | Improving Access to Medical Care through Tax Treatment of PhysiciansGregory Pinto, MD, DelegateRESOLVED, That our American Medical Association seek legislation and/or regulation that would permit physician practices to utilize ‘pass through’ tax treatment of practice income in the manner of other small businesses and professionals. (Directive to Take Action) |
| B | Res. 240# | Formation of Collective Bargaining WorkgroupHawaiiRESOLVED, That our American Medical Association form a workgroup to outline the legal challenge to federal antitrust statute for physicians (Directive to Take Action); and be it furtherRESOLVED, That this workgroup engage the state medical associations and other physician groups as deemed appropriate (Directive to Take Action); andRESOLVED, That our AMA report by the 2020 Annual Meeting on the viability of a strategy for the formation of a federal collective bargaining system for all physicians and, to the extent viable, a related organizational plan. (Directive to Take Action) |
| B | Res. 241# | Facilitation of Research with Medicare Claims DataConnecticutRESOLVED, That our American Medical Association, in an effort to advance the feasibility of population health research to fulfill the promise of value based care, request that the Centers for Medicare and Medicaid Services (CMS) and CMS’s Centers for Medicare and Medicaid Innovation (CMMI) eliminate the prohibitions on sharing data outside of the accountable care organization contained in the CMS Data Use Agreement and allow sharing of that data: (1) in the form of de-identified data sets as permitted by HIPAA; and (2) for purposes of research as permitted by HIPAA. (Directive to Take Action) |
| B | Res. 242\* | Improving Health Information Technology Products to Properly Care for LGBTQ PatientsTexasRESOLVED, That our American Medical Association research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity (Directive to Take Action); and be it further RESOLVED, That our AMA investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians. (Directive to Take Action) |
| B | Res. 243\* | Improving the Quality Payment Program and Preserving Patient AccessTexasRESOLVED, That our American Medical Association strongly advocate for Congress to make participation in the Merit-Based Incentive Payment System and alternative payment models under the Quality Payment Program completely voluntary (Directive to Take Action); and be it further RESOLVED, That our AMA strongly advocate for Congress to eliminate budget neutrality in the Merit-Based Incentive Payment System and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians (Directive to Take Action); and be it furtherRESOLVED, That our AMA call on the Centers for Medicare & Medicaid Services (CMS) to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so physicians and medical societies can analyze the data to advocate for additional exemptions; flexibilities; and reductions in reporting burdens, administrative hassles, and costs (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate that CMS increase the low-volume threshold for the 2020 Quality Payment Program and future years of the program for all physicians and continue to offer them the opportunity to opt in or voluntarily report (Directive to Take Action); and be it furtherRESOLVED, That our AMA reaffirm Policy H-390.838, “MIPS and MACRA Exemption,” and advocate to preserve patient access by exempting small practices (one to 15 clinicians) from required participation in the Merit-Based Incentive Payment System and continue to offer them the opportunity to opt in or voluntarily report. (Reaffirm HOD Policy) |
| B | Res. 244\* | EHR-Integrated Prescription Drug Monitoring Program Rapid AccessOrganized Medical Staff SectionRESOLVED, That our American Medical Association advocate, at the state and national levels, to promote Prescription Drug Monitoring Program (PDMP) integration/access within Electronic Health Record workflows (of all developers/vendors) at no cost to the physician or other authorized health care provider. (Directive to Take Action) |
| B | Res. 245\* | Sensible Appropriate Use Criteria In MedicareOrganized Medical Staff SectionRESOLVED, That our American Medical Association Policy H-320.940, “Medicare's Appropriate Use Criteria Program,” be amended by addition as follows:Our AMA will continue to advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid Services can adequately address technical and workflow challenges with its implementation and any interaction between the Quality Payment Program (QPP) and the use of advanced diagnostic imaging appropriate use criteria, and support regulatory change that resolves technical and workflow challenges and/or removes barriers to modifying or aligning the AUC Program and the QPP. (Modify HOD Policy) |
| B | Res. 246\* | Call for Transparency Regarding the Announcement of 17,000 Cuts to Military Health ProvidersMedical Student SectionRESOLVED, That our American Medical Association urge the Department of Defense to immediately and publicly release the required assessments that the Military Departments, the Joint Staff, and organizations within the Office of the Secretary of Defense reportedly conducted as submitted in writing by the US Army Surgeon General in Congressional testimony to Senate Appropriations Committee regarding the operational medical requirements needed to support the National Defense Strategy that the Military Departments used in planning to reduce overall uniformed medical positions, as well as provide immediate clarification regarding the proposed cuts including the number of medical provider billet cuts and their distribution amongst specialties and services (Directive to Take Action); and be it furtherRESOLVED, That if no such Department of Defense assessments exist, are immediately released, or appear inadequate to the AMA to justify the proposed cuts to military billets, that our AMA urgently lobby the US Congress to implement legislation mandating a study in the next National Defense Authorization Act to assess the impact of potential cuts on cost and healthcare quality outcomes for military service members, dependents, and retirees before drastic cuts are executed (Directive to Take Action); and be it furtherRESOLVED, That our AMA strongly oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for parity civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States’ physician shortage. (Directive to Take Action) |
| C | BOT 25 | All Payer Graduate Medical Education Funding1. The Board recommends that our AMA amend Policy D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” with the addition of a new clause to read as follows, and that the remainder of the report be filed:Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs. (Modify Current HOD Policy)2. That our AMA rescind section 33 of Policy D-305.967, which directed the AMA to conduct the study herein. (Rescind AMA Policy) |
| C | CME 02 | Update on Maintenance of Certification and Osteopathic Continuous Certification1. That our American Medical Association (AMA), through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification. (Directive to Take Action)2. That our AMA, to be consistent with terminology now used by the American Board of Medical Specialties, amend the following policies by addition and deletion to read as follows:Policy H-275.924, Amend the title to read, “~~Maintenance of~~ Continuing Board Certification” (AMA Principles on ~~Maintenance of~~ Continuing Board Certification), and replace the terms “Maintenance of Certification” and “MOC” with “Continuing Board Certification” and “CBC” throughout the policy, as shown in Appendix H.Policy D-275.954, Amend the title to read, “~~Maintenance of Certification and Osteopathic Continuous Certification~~ Continuing Board Certification,” and replace the terms “Maintenance of Certification” and “MOC” with “Continuing Board Certification” and “CBC” throughout the policy, as shown in Appendix H. (Modify Current HOD Policy)3. That our AMA rescind Policy D-275.954 (37), “Maintenance of Certification and Osteopathic Continuous Certification,” that asks the AMA to “Through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission,” as this has been accomplished. (Rescind HOD Policy)4. That our AMA rescind Policy D-275.954 (38), which asks our AMA to “Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards,” as this has been accomplished. (Rescind HOD Policy)5. That our AMA rescind Policy D- 275.954 (39) “Maintenance of Certification and Osteopathic Continuous Certification,” as this has been accomplished through this report. (Rescind HOD Policy) |
| C | CME 03 | Standardizing the Residency Match System and Timeline1. That our AMA encourage appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions. (Directive to Take Action)2. That our AMA work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) to create local PGY-1 positions that will enable coordinated applications and interviews for medical students. (Directive to Take Action)3. That our AMA encourage the NRMP to design a process that will allow competency-based student graduation and off-cycle entry into residency programs. (Directive to Take Action)4. That our AMA encourage the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, and to ensure that all applicants have access to robust, informative statistics to assist in decision-making. (Directive to Take Action) |
| C | CME 04 | Augmented Intelligence in Medical Education1. That our American Medical Association (AMA) encourage accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards. (Directive to Take Action)2. That our AMA encourage medical specialty societies and boards to consider production of specialty-specific educational modules related to AI. (Directive to Take Action)3. That our AMA encourage research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes. (Directive to Take Action)4. That our AMA encourage institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules. (Directive to Take Action)5. That our AMA encourage stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems. (Directive to Take Action)6. That our AMA encourage enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients. (Directive to Take Action)7. That our AMA encourage institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI. (Directive to Take Action)8. That Policy D-295.328, “Promoting Physician Lifelong Learning,” be reaffirmed. (Reaffirm HOD Policy) |
| C | CME 06 | Study of Medical Student, Resident, and Physician Suicide1. That our American Medical Association (AMA) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies. (Directive to Take Action)2. That our AMA monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events. (Directive to Take Action)3. That our AMA supports the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free behavioral health services. (Directive to Take Action)4. That our AMA collaborate with other stakeholders to study the incidence of suicide among physicians, residents, and medical students. (Directive to Take Action)5. That Policy D-345.984, “Study of Medical Student, Resident, and Physician Suicide,” be rescinded, as having been fulfilled by this report and through requests for action by the Liaison Committee on Medical Education and ACGME. (Rescind HOD Policy) |
| C | CME/CSAPH 01 | Protecting Medical Trainees from Hazardous Exposure1. That our American Medical Association (AMA) amend Policy H-295.939, “OSHA Regulations for Students,” by addition and deletion, to read as follows:H-295.939, “~~OSHA Regulations for Students~~ Protecting Medical Trainees from Hazardous Exposure”Our AMA will ~~The AMA, working in conjunction with its Medical School Section, to~~ encourage~~s~~ all health care-related educational institutions to apply the ~~existing~~ Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen ~~S~~standard~~s~~ and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows~~students~~. (Modify Current HOD Policy)2. That our AMA recommend that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site. (New HOD Policy)3. That our AMA recommend a) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students’ ability to successfully complete their training, and b) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to minimize the risks of hazardous exposures that may affect her personal health status. (New HOD Policy)4. That our AMA recommend that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff. (New HOD Policy)5. That our AMA recommend that medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff. (New HOD Policy) |
| C | Res. 301 | American Board of Medical Specialties AdvertisingVirginiaRESOLVED, That our American Medical Association oppose the use of any physician fees, dues, etc., for any advertising by the American Board of Medical Specialties or any of their component boards to the general public. (New HOD Policy) |
| C | Res. 302 | The Climate Change Lecture for US Medical SchoolsAmerican Association of Public Health PhysiciansRESOLVED, That our American Medical Association recommend that one hour of teaching on climate change, “The Climate Change Lecture”, be required for all medical students before graduation with the M.D. or D.O. degree as a minimum standard, with more than one hour of teaching encouraged for medical schools that so choose (Directive to Take Action); and be it furtherRESOLVED, That our AMA recommend that the goals of “The Climate Change Lecture” be for medical students upon graduation to have a basic knowledge of the science of climate change, to be able to describe the risks that climate change poses to human health, and be prepared to advise patients how to protect themselves from the health risks posed by climate change (Directive to Take Action); and be it furtherRESOLVED, That our AMA recommend that medical schools be exempted from the requirement of “The Climate Change Lecture” that have already implemented pedagogy on this topic that amounts to an hour or more of required learning on climate change and health for medical students (Directive to Take Action); and be it furtherRESOLVED, That our AMA prepare a prototype PowerPoint slide presentation and lecture notes for “The Climate Change Lecture”, which could be used by medical schools, or schools may create their own lecture, video or online course to fulfill the requirements of “The Climate Change Lecture” (Directive to Take Action); and be it furtherRESOLVED, That our AMA write to the Commission on Osteopathic College Accreditation (COCA) which is the accrediting organization for schools offering the D.O. degree in the United States; to the Liaison Committee on Medical Education (LCME), which is the accrediting organization for schools offering the M.D. degree in the United States (including for the Uniformed Services University of the Health Sciences); and to the LCME representative from the AMA Medical Student Section, to recommend that “The Climate Change Lecture”, using AMA’s prototype PowerPoint presentation and notes, or other formats, become a requirement for all M.D. and D.O. degrees for United States medical schools beginning with 2021 graduates (Directive to Take Action); and be it furtherRESOLVED, That our AMA delegation to the World Medical Association present a similar resolution to the World Medical Association recommending the concept of the “The Climate Change Lecture” for medical schools worldwide. (Directive to Take Action) |
| C | Res. 303 | Graduate Medical Education and the Corporate Practice of MedicineCaliforniaRESOLVED, That our American Medical Association recognize and support that the environment for education of residents and fellows must be free of the conflict of interest created between corporate-owned lay entities' fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs (New HOD Policy); and be it furtherRESOLVED, That our AMA support that the Accreditation Council for Graduate Medical Education require that graduate medical education programs must be established in compliance with all state laws, including prohibitions on the corporate practice of medicine, as a condition of accreditation. (New HOD Policy) |
| C | Res. 304 | Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline ProgramsCaliforniaRESOLVED, That our American Medical Association support the publication of a white paper chronicling health care career pipeline programs across the nation aimed at increasing the number programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs. (Directive to Take Action) |
| C | Res. 305 | Lack of Support for Maintenance of CertificationIllinoisRESOLVED, That our American Medical Association urge all American Board of Medical Specialties (ABMS) Boards to phase out the use of mandated, periodic, pass/fail, point-in-time examinations, and Quality Improvement/Practice Improvement components of the Maintenance of Certification process, and replace them with more longitudinal and formative assessment strategies that provide feedback for continuous learning and improvement and support a physician’s commitment to ongoing professional development (Directive to Take Action); and be it furtherRESOLVED, That our AMA encourage all ABMS Boards to adopt and immediately begin the process of implementing the following recommendation from the Continuing Board Certification Vision For the Future Commission Final Report: “Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge.” (Directive to Take Action) |
| C | Res. 306 | Interest Rates and Medical EducationIllinoisRESOLVED, That our American Medical Association reaffirm Policy H-305.925, “Principles of and Actions to Address Medical Education Costs and Student Debt.” (Reaffirm HOD Policy) |
| C | Res. 307 | Mental Health Services for Medical StudentsNew YorkRESOLVED, That our American Medical Association recommend that the Association of American Medical Colleges strengthen their recommendations to all medical schools that medical schools provide confidential in-house mental health services at no cost to students, without billing health insurance, and that they set up programs to educate both students and staff about burnout, depression, and suicide. (Directive to Take Action) |
| C | Res. 308 | Maintenance of Certification MoratoriumNew YorkRESOLVED, That our American Medical Association call for an immediate end to the high stakes examination components as well as an end to the Quality Initiative (QI)/Practice Improvement (PI) components of Maintenance of Certification (MOC) (Directive to Take Action); and be it furtherRESOLVED, That our AMA call for retention of continuing medical education (CME) and professionalism components (how physicians carry out their responsibilities safely and ethically) of MOC only (Directive to Take Action); and be it furtherRESOLVED, That our AMA petition the American Board of Medical Specialties for the restoration of certification status for all diplomates who have lost certification status solely because they have not complied with MOC requirements. (Directive to Take Action) |
| C | Res. 309 | Promoting Addiction Medicine During a Time of CrisisNew YorkRESOLVED, That our American Medical Association endorse and support the incorporation of addiction medicine science into medical student education and residency training (New HOD Policy); and be it furtherRESOLVED, That our AMA transmit this resolution to the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education (ACGME). (Directive to Take Action) |
| C | Res. 310 | Mental Health Care for Medical StudentsNew YorkRESOLVED, That our American Medical Association encourage all medical schools to assign a mental health provider to every incoming medical student (New HOD Policy); and be it furtherRESOLVED, That our AMA encourage all medical schools to provide an easy way for medical students to select a different provider at any time (New HOD Policy); and be it furtherRESOLVED, That our AMA encourage all medical schools to require each student’s mental health professional or related staff to contact the student once per semester to ask if the student would like to meet with their mental health professional, unless the student already has an appointment to do so or has asked not to be contacted with regards to mental health appointments (New HOD Policy); and be it furtherRESOLVED, That our AMA encourage all medical schools to provide an easy process for students to initiate treatment with school mental health professionals at no cost to the student or professional from the mental health community at affordable cost to the student, and without undue bureaucratic burden. (New HOD Policy) |
| C | Res. 311 | Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical LicensureInternational Medical Graduates SectionRESOLVED, That the American Medical Association work with the Federation of State Medical Boards, the Organized Medical Staff Section and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. Healthcare system. (Directive to Take Action) |
| C | Res. 312 | Unmatched Medical Graduates to Address the Shortage of Primary Care PhysiciansInternational Medical Graduates SectionRESOLVED, That our American Medical Association advocate for the state medical boards to accept medical graduates who have passed USMLE Steps 1 and 2 as their criterion for limited license, thus using the existing physician workforce of trained and certified physicians in the primary care field and allowing them to get some credit towards their residency training as is being contemplated in Utah (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with regulatory, licensing, medical, and educational entities dealing with physician workforce issues: the American Board of Medical Specialties, the Association of American Medical Colleges (AAMC), the Association for Hospital Medical Education, Accreditation Council for Graduate Medical Education (ACGME), the Federation of State Medical Boards, and the National Medical Association work together to integrate unmatched physicians in the primary care workforce in order to address the projected physician shortage. (Directive to Take Action) |
| C | Res. 313 | Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and FellowsResident and Fellow SectionRESOLVED, That our American Medical Association study current standards within medical education regarding pathology and laboratory medicine to identify potential gaps in training. (Directive to Take Action) |
| C | Res. 314 | Evaluation of Changes to Residency and Fellowship Application and Matching ProcessesResident and Fellow SectionRESOLVED, That our American Medical Association support proposed changes to residency and fellowship application requirements only when (a) those changes have been evaluated by working groups which have students and residents as representatives; (b) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate; (c) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds; and (4) the costs to medical students and residents are mitigated (New HOD Policy): and be it furtherRESOLVED, That our AMA oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met (New HOD Policy); and be it furtherRESOLVED, That our AMA continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements. (Directive to Take Action) |
| C | Res. 315 | Scholarly Activity by Resident and Fellow PhysiciansResident and Fellow SectionRESOLVED, That our American Medical Association define resident and fellow scholarly activity as any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity (New HOD Policy); and be it furtherRESOLVED, That our AMA work with partner organizations to ensure that residents and fellows are able to fulfill scholarly activity requirements with any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity. (Directive to Take Action) |
| C | Res. 316 | Medical Student DebtSenior Physicians SectionRESOLVED, That our American Medical Association formulate a task force to look at undergraduate medical education training as it relates to specialty choice, and develop new polices and novel approaches to prevent debt from influencing primary care specialty choice. (Directive to Take Action) |
| C | Res. 317 | A Study to Evaluate Barriers to Medical Education for Trainees with DisabilitiesResident and Fellow SectionRESOLVED, That our American Medical Association work with relevant stakeholders to study available data on medical trainees with disabilities and consider revision of technical standards for medical education programs. (Directive to Take Action) |
| C | Res. 318 | Rural Health Physician Workforce DisparitiesIowaRESOLVED, That our American Medical Association undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies to alleviate rural physician workforce shortages. (Directive to Take Action) |
| C | Res. 319# | Adding Pipeline Program Participation Questions to Medical School ApplicationsMinority Affairs SectionRESOLVED, That our American Medical Association collaborate with the Association of American Medical Colleges (AAMC) and other stakeholders to coalesce the data to create a question for the AAMC electronic medical school application to allow applicants to identify previous pipeline program participation to determine the effectiveness of pipeline programs those who are underrepresented in medicine in their decisions to pursue careers in medicine (Directive to Take Action); andRESOLVED, That our AMA develop a plan to analyze the data once this question is implemented with input from key stakeholders, including AAMC, the Accreditation Council for Graduate Medical Education, and interested medical societies and premed pipeline programs. (Directive to Take Action) |
| C | Res. 320# | Opioid Education in Medical SchoolsMichiganRESOLVED, That our American Medical Association work with the Liaison Committee on Medical Education to include formalized opioid and related substance use disorder training using an evidence-based multidisciplinary approach in the curriculum of accredited medical schools. (New HOD Policy) |
| C | Res. 321# | Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical ProfessionMichiganRESOLVED, That our American Medical Association amend policy D-405.990, “Educating Physicians About Physician Health Programs,” by addition to read as follows: Educating Physicians About Physician Health Programs and Advocating for Standards D-405.9901) 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; and 5) Our AMA will continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; 6) Our AMA will continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options. (Modify Current HOD Policy) |
| C | Res. 322# | Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical SchoolsMedical Student SectionRESOLVED, That our American Medical Association support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved. (New HOD Policy) |
| C | Res. 323\* | Improving Access to Care in Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project ModelTexasRESOLVED, That our American Medical Association promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States (Directive to Take Action); and be it further RESOLVED, That our AMA monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians. (Directive to Take Action) |
| D | Res. 324\* | Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary ReimbursementResident and Fellow SectionRESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or “protected time” for resident and fellow education by “core faculty,” program directors, and assistant/associate program directors. (Directive to Action) |
| D | BOT 11 | Policy and Economic Support for Early Child Care1. That our AMA reaffirm Policy H-440.823, which recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member. (Reaffirm HOD Policy)2. That our AMA encourage employers to offer and/or expand paid parental leave policies. (New HOD Policy)3. That our AMA encourage state medical associations to work with their state legislatures to establish and promote paid parental leave policies. (New HOD Policy)4. That our AMA advocate for improved social and economic support for paid family leave to care for newborns, infants and young children (New HOD Policy)5. That our AMA advocate for federal tax incentives to support early child care and unpaid child care by extended family members (New HOD Policy). |
| D | BOT 16 | Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients1. That our American Medical Association partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs. (Directive to Take Action)2. That our AMA encourage the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital. (New HOD Policy)3. That our AMA encourage the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients. (New HOD Policy)4. That our AMA reaffirm Policy H-160.903, Eradicating Homelessness, which "supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services." (Reaffirm HOD Policy)5. That our AMA reaffirm Policy H-160.978, The Mentally Ill Homeless, which states that “public policy initiatives directed to the homeless, including the homeless mentally ill population, should…[promote] care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities.” (Reaffirm HOD Policy)6. That our AMA reaffirm Policy H-160.942, Evidence-Based Principles of Discharge and Discharge Criteria, which "calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients." (Reaffirm HOD Policy)7. That our AMA reaffirm Policy H-130.940, Emergency Department Boarding and Crowding, which “supports dissemination of best practices in reducing emergency department boarding and crowding.” (Reaffirm HOD Policy)8. That our AMA reaffirm Policy H-270.962, Unfunded Mandates, which “vigorously opposes any unfunded mandates on physicians.” (Reaffirm HOD Policy) |
| D | BOT 28 | Opposition to Measures that Criminalize Homelessness1. That our American Medical Association: (1) supports laws protecting the civil and human rights of individuals experiencing homelessness and (2) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available. (New HOD Policy)2. That our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods. (New HOD Policy)3. That our AMA reaffirm Policy H-160.903, “Eradicating Homelessness”Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis; (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; and (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons. (Reaffirm Current HOD Policy) |
| D | BOT 29 | Improving Safety and Health Code Compliance in School Facilities1. That our AMA adopt the following new policy:“Environmental Health and Safety in Schools”Our AMA supports the adoption of standards in schools that limit harmful substances from school facility environments, ensure safe drinking water, and indoor air quality, and promote childhood environmental health and safety in an equitable manner. (New HOD Policy)2. That the following policies be reaffirmed: H-135.928, “Safe Drinking Water,” and H-135.998, “AMA Position on Air Pollution.” (Reaffirm HOD Policy) |
| D | CSAPH 03 | Low Nicotine Product Standard1. That AMA Policy H-495.988, “FDA Regulation of Tobacco Products” be amended by addition to read as follows:1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.3. Our AMA: (A) will continue to monitor the FDA’s progress towards establishing a low nicotine product standard for tobacco products and will submit comments on the proposed rule that are in line with the current scientific evidence and (B) recognizes that rigorous and comprehensive post-market surveillance and product testing to monitor for unintended tobacco use patterns will be critical to the success of a nicotine reduction policy. (Modify Current HOD Policy)2. That American Medical Association Policy H-495.972, “Electronic Cigarettes, Vaping, and Health” be reaffirmed. (Reaffirm HOD Policy) |
| D | CSAPH 04 | Vector-borne Diseases1. That Policy H-440.820, “Vector-Borne Diseases,” be amended by addition and deletion to read as follows:H-440.820 Vector-Borne DiseasesDue to the increasing threat and limited capacity to respond to vector-borne diseases, ~~Our~~ our AMA supports and will advocate for ~~local, state and national research, education, reporting and tracking on vector-borne diseases~~.(1) Improved surveillance for vector-borne diseases to better understand the geographic distribution of infectious vectors and where people are at risk;(2) The development and funding of comprehensive and coordinated vector-borne disease prevention and control programs at the state and local level;(3) Investments that strengthen our nation’s public health infrastructure and the public health workforce;(4) Education and training for health care professionals and the public about the risk of vector-borne diseases and prevention efforts as well as the dissemination of available information;(5) Research to develop new vaccines, diagnostics, and treatments for existing and emerging vector-borne diseases, including Lyme disease;(6) Research to identify novel methods for controlling vectors and vector-borne diseases; and(7) Increased and sustained funding to address the growing burden of vector-borne diseases in the United States. (Modify Current HOD Policy)2. That Policy H-135.938, “Global Climate Change and Human Health” and Policy, D-440.940, “Global Tracking System of Zoonotic Diseases,” be reaffirmed. (Reaffirm HOD Policy) |
| D | Res. 401 | Support Pregnancy Intention Screenings to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended PregnanciesOregonRESOLVED, That our American Medical Association support the use of pregnancy intention screening, such as One Key Question®, PATH, or the Centers for Disease Control and Prevention (CDC) reproductive life planning, as part of routine well care and recommend it be built in electronic health records so that providers can document intention screening and services provided based on a woman’s response. (New HOD Policy) |
| D | Res. 402 | Bullying in the Practice of MedicineYoung Physicians SectionRESOLVED, That our American Medical Association help establish a clear definition of professional bullying, establish prevalence and impact of professional bullying, and establish guidelines for prevention of professional bullying with a report back at the 2020 Annual Meeting. (Directive to Take Action) |
| D | Res. 403 | White House Initiative on Asian Americans and Pacific IslandersYoung Physicians SectionRESOLVED, That our American Medical Association advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data (Directive to Take Action); and be it furtherRESOLVED, That our AMA support the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes (Directive to Take Action); and be it furtherRESOLVED, That our AMA support the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine (Directive to Take Action); and be it furtherRESOLVED, That our AMA report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine. (Directive to Take Action) |
| D | Res. 404 | Shade Structures in Public and Private Planning and Zoning MattersConnecticutRESOLVED, 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. (New HOD Policy) |
| D | Res. 405 | Gun Violence Prevention: Safety FeaturesCaliforniaRESOLVED, That our American Medical Association advocate for gun safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these gun safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured guns. (Directive to Take Action) |
| D | Res. 406 | Reduction in Consumption of Processed MeatsCaliforniaRESOLVED, That our American Medical Association support reduction of processed meat consumption, especially for patients diagnosed or at risk for coronary artery disease, type 2 diabetes and colorectal cancer (New HOD Policy); and be it furtherRESOLVED, That our AMA support initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition (New HOD Policy); and be it furtherRESOLVED, That our AMA support public awareness of the risks of processed meat consumption, including research that better defines the health risks imposed by different methods of meat processing (New HOD Policy); and be it furtherRESOLVED, That our AMA support educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives. (New HOD Policy) |
| D | Res. 407 | Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle AccidentsCaliforniaRESOLVED, That our American Medical Association monitor the development of autonomous vehicles, with particular focus on the technology’s impact on motor vehicle related injury and death (Directive to Take Action); and be it furtherRESOLVED, That our AMA promote driver, pedestrian, and general street and traffic safety as key priorities in the development of autonomous vehicles. (Directive to Take Action) |
| D | Res. 408 | Banning Edible Cannabis ProductsIllinoisRESOLVED, That our American Medical Association adopt policy supporting a total ban on recreational edible cannabis products (New HOD Policy); and be it furtherRESOLVED, That our AMA support or cause to be introduced legislation to ban all recreational edible cannabis products. (Directive to Take Action) |
| D | Res. 409 | Addressing the Vaping CrisisNew YorkRESOLVED, That our American Medical Association advocate to the Food and Drug Administration that vaping devices should be available only by prescription for smokers who are trying to quit smoking. (Directive to Take Action) |
| D | Res. 410 | Reducing Health Disparities Through EducationNew YorkRESOLVED, That our American Medical Association work with the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with HHS and DOE to establish a meaningful health curriculum (including nutrition) for grades kindergarten through 12 which is required for high school graduation (Directive to Take Action); and be it furtherRESOLVED, That our AMA work nationally toward the same goals and strategies to reduce health disparities. (Directive to Take Action) |
| D | Res. 411 | AMA to Analyze Benefits / Harms of Legalization of MarijuanaNew YorkRESOLVED, That our American Medical Association review pertinent data from those states that have legalized marijuana. (Directive to Take Action) |
| D | Res. 412 | Regulating Liquid Nicotine and E-CigarettesNew YorkRESOLVED, That our American Medical Association seek legislation or regulations that limit higher concentration nicotine salts (greater than 10mg) in nicotine vaping pods and restrict bulk sale of vaping products and associated paraphernalia. (Directive to Take Action) |
| D | Res. 413 | End the Epidemic of HIV NationallyNew YorkRESOLVED, That our American Medical Association advocate that the federal budget include provisions to End the HIV epidemic and that such a plan be structured after New York State's EtE 2020 or other similar state programs. (Directive to Take Action) |
| D | Res. 414 | Patient Medical Marijuana Use in HospitalsOklahomaRESOLVED, That our American Medical Association offer guidance to medical staffs regarding patient use of non-US Food and Drug Administration approved medical marijuana and cannabinoids on hospital property, including product use, storage in patient rooms, nursing areas and/or pharmacy, with report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action) |
| D | Res. 415 | Distracted Driver LegislationOklahomaRESOLVED, That our American Medical Association actively lobby for federal legislation to decrease distracted driving injuries and fatalities by banning the use of electronic communication such as texting, taking photos or video and posting on social media while operating a motor vehicle; (Directive to Take Action) and be it furtherRESOLVED, That our AMA actively lobby for federal legislation to require automobile manufacturers to integrate hands-free technology into new automobiles. (Directive to Take Action) |
| D | Res. 416 | Non-Medical Exemptions from ImmunizationsOklahomaRESOLVED, That our American Medical Association actively advocate for federal legislation that incentivizes states to eliminate non-medical exemptions to mandated pediatric immunizations. (Directive to Take Action) |
| D | Res. 417 | Improved Health in the United States Prison System through Hygiene and Health Educational Programming for Inmates and Prison StaffPennsylvaniaRESOLVED, That our American Medical Association collaborate with state medical societies to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in state and local prison systems. (Directive to Take Action) |
| D | Res. 418 | Eliminating the Death Toll from Combustible CigarettesWashingtonRESOLVED, That our American Medical Association study and report on the conditions under which our country could successfully eliminate the manufacture, distribution, and sale of combustible cigarettes and other combustible tobacco products at the earliest feasible date. (Directive to Take Action) |
| D | Res. 419 | Universal Access for Essential Public Health ServicesWashingtonRESOLVED, That our American Medical Association study the options and/or make recommendations regarding the establishment of:1. A list of all essential public health services that should be provided in every jurisdiction in the United States.2. A federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services.3. A federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction (Directive to Take Action); and be it furtherRESOLVED, That our AMA prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services. (Directive to Take Action) |
| D | Res. 420 | Coordinating Correctional and Community HealthcareResident and Fellow SectionRESOLVED, That our American Medical Association support linkage of those incarcerated to community clinics upon release in order to accelerate access to primary care and improve health outcomes among this vulnerable patient population, as well as adequate funding (New HOD Policy); and be it furtherRESOLVED, That our AMA support the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (New HOD Policy) |
| D | Res. 421 | Contraception for Incarcerated WomenResident and Fellow SectionRESOLVED, That our American Medical Association support incarcerated persons’ access to evidence-based contraception counseling, access to all contraceptive methods and autonomy over contraceptive decision-making prior to release. (New HOD Policy) |
| D | Res. 422 | Promoting Nutrition Education Among Healthcare ProvidersResident and Fellow SectionRESOLVED, That American Medical Association Policy H-150.995, “Basic Courses in Nutrition, be reaffirmed (Reaffirm HOD Policy); and be it furtherRESOLVED, That AMA Policy H-150.953, “Obesity as a Major Public Health Problem,” be reaffirmed. (Reaffirm HOD Policy) |
| D | Res. 423# | Mandatory Immunizations for Asylum SeekersAmerican Academy of PediatricsRESOLVED, That our American Medical Association call for asylum seekers to receive all medically-appropriate vaccinations upon presentation for asylum regardless of country of origin. (Directive to Take Action) |
| D | Res. 424# | Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain InjuryAmerican Academy of Physical Medicine and RehabilitationRESOLVED, That our American Medical Association reaffirm current AMA policy, H 145.999, “Gun Regulation,” stating it supports stricter enforcement of current federal and state gun legislation (Reaffirm HOD Policy); and be it furtherRESOLVED, That our AMA advocate for physician-led committees in each state to give further recommendations to the state regarding driving and/or gun use by individuals who are cognitively impaired and/or a danger to themselves or others. (Directive to Take Action)  |
| D | Res. 425# | Distracted Driver Education and AdvocacyGeorgiaRESOLVED, That our American Medical Association make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with the Centers for Disease Control and other interested stakeholders (Directive to Take Action); and be it furtherRESOLVED, That our AMA explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action) |
| D | Res. 426# | Health Care Accreditation of Correctional, Detention and Juvenile FacilitiesMinority Affairs SectionRESOLVED, That our American Medical Association work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC), American Correctional Association (ACA) and others with accreditation expertise, in developing a strategy to accredit all correctional, detention and juvenile facilities (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate that all correctional, detention and juvenile facilities be accredited by a national accrediting organization, such as the NCCHC or ACA, no later than 2025. (Directive to Take Action) |
| D | Res. 427# | Utility of Autonomous Vehicles for Individuals Who are Visually Impaired or Developmentally DisabledMichiganRESOLVED, That our American Medical Association work with the National Transportation Safety Board to support physician input on research into the capability of autonomous or “self-driving” vehicles to enable individuals who are visually impaired or developmentally disabled to benefit from autonomous vehicle technology. (Directive to Take Action) |
| D | Res. 428# | Dangers of VapingMichiganRESOLVED, That our American Medical Association amend existing policy H-495.986, “Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E‑cigarettes,” by addition to read as follows:Our AMA:(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21 and requirements to include warning labels on all electronic nicotine delivery systems (ENDS);(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years and require warning labels on all ENDS, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;(3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; and (g) requirements for warning labels on all ENDS;(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and(9) opposes the sale of tobacco at any facility where health services are provided; and(10) supports that the sale of tobacco products be restricted to tobacco specialty stores. (Modify Current HOD Policy) |
| D | Res. 429# | MOVED TO REF COMM E (NOW RESOLUTION 531) |
| D | Res. 430# | Compassionate Release for Incarcerated PatientsMedical Student SectionRESOLVED, That our American Medical Association support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age (New HOD Policy); and be it furtherRESOLVED, That our AMA collaborate with appropriate stakeholders to draft model legislationthat establishes clear, evidence-based eligibility criteria for timely compassionate release (Directive to Take Action); and be it furtherRESOLVED, That our AMA promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions. (Directive to Take Action) |
| D | Res. 431# | Eliminating Recommendations to Restrict Dietary Cholesterol and FatMedical Student SectionRESOLVED, That our American Medical Association amend Policy H-150.944, “Combating Obesity and Health Disparities,” by addition and deletion to read as follows:H-150.944 Combating Obesity and Health DisparitiesOur AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of ~~foods and beverages low in fat, added sugars, and cholesterol,~~ healthful foods and beverages. (Modify Current HOD Policy) |
| D | Res. 432# | Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed IndividualsMedical Student SectionRESOLVED, That our American Medical Association support repealing legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV who have an undetectable viral load. (New HOD Policy) |
| D | Res. 433# | Transformation of Rural Community Public Health SystemsNebraskaRESOLVED, That our American Medical Association work with other entities and organizations interested in public health to:- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities- Periodically study efforts to optimize rural public health. (Directive to Take Action) |
| D | Res. 434# | Change in Marijuana Classification to Allow ResearchNew JerseyRESOLVED, That our American Medical Association petition the US Food and Drug Administration / US Drug Enforcement Administration to change the schedule classification of marijuana so that it can be subjected to appropriate research. (Directive to Take Action) |
| E | CSAPH 1 | CSAPH Sunset Review of 2009 House of Delegates PoliciesThe Council on Science and Public Health recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of the report be filed. (Directive to Take Action) |
| E | Res. 501 | USP 800VirginiaRESOLVED, That our American Medical Association adopt as policy that physicians and other health care providers administering medications (defined as the mixing or reconstituting of a drug according to manufacturers' recommendations for a single patient for immediate use) not be subject to the USP 800 compounding guidance (New HOD Policy); and be it furtherRESOLVED, That our AMA support development of specialty specific white papers/best practices and systems for both safe medication administration practices and ongoing monitoring of potential complications from the administration of medications deemed suitable for exemptions from the National Institute for Occupational Safety and Health, United States Pharmacopeia, and other regulatory bodies when used in an office setting under the direction of a licensed physician (New HOD Policy); and be it furtherRESOLVED, That our AMA continue its working group, consisting of national specialty organizations, state medical societies and other stakeholders to advocate for such exemptions. (Directive to Take Action) |
| E | Res. 502 | Destigmatizing the Language of AddictionYoung Physicians SectionRESOLVED, That our American Medical Association use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty (New HOD Policy); and be it furtherRESOLVED, That our AMA and relevant stakeholders create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities. (Directive to Take Action) |
| E | Res. 503 | Addressing Healthcare Needs of Children of Incarcerated ParentsMissouriRESOLVED, That our American Medical Association support comprehensive and evidence-based care that addresses the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who are at risk. (New HOD Policy) |
| E | Res. 504 | Screening, Intervention, and Treatment for Adverse Childhood ExperiencesCaliforniaRESOLVED, That our American Medical Association support efforts for data collection, research and evaluation of Adverse Childhood Experiences (ACEs), cost-effective ACE screening tools without additional burden for physicians, and effective interventions, treatments and support services necessary for a positive screening practice in pediatric and adult populations (New HOD Policy); and be it furtherRESOLVED, That our AMA support efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACE screening and trauma-informed care approaches into a clinical setting (New HOD Policy); and be it furtherRESOLVED, That our AMA support additional funding sources for schools, behavioral and mental health services, professional groups, community and government agencies to support children and adults with ACEs. (New HOD Policy) |
| E | Res. 505 | Glyphosate StudiesCaliforniaRESOLVED, That our American Medical Association advocate for a reduction in the use of glyphosate-based pesticides (the primary chemical in the herbicide branded Roundup), encourage the evaluation of alternatives, and support additional research to determine the long-term effects and association between glyphosate and disease. (Directive to Take Action) |
| E | Res. 506 | Clarify Advertising and Contents of Herbal Remedies and Dietary SupplementsIllinoisRESOLVED, That our American Medical Association work with the National Center for Complementary and Integrative Health (NCCIH), the federal agency responsible for oversight of herbal remedies and dietary supplements, to institute stricter guidelines for advertising and labeling of these products so that consumers will be informed of what they are purchasing (Directive to Take Action); and be it furtherRESOLVED, that our AMA support a licensing body through legislation for manufacturers of dietary supplements and herbal remedies, with the requirement that those manufacturers must supply proof that their products have health benefits (Directive to Take Action); and be it furtherRESOLVED, That our AMA urge that the increased cost of a stricter NCCIH program on dietary supplements and herbal remedies be paid for by the manufacturers who produce them. (Directive to Take Action) |
| E | Res. 507 | Removing Ethylene Oxide as a Medical Sterilant from HealthcareIllinoisRESOLVED, That our American Medical Association adopt as policy and urge, as appropriate, the prevention of ethylene oxide emissions and substitution of ethylene oxide with less toxic sterilization alternatives that are currently available, including hydrogen peroxide, steam, and other safer alternatives, which do not release carcinogens into the workplace or community air and allow no residual exposures to the patient (New HOD Policy); and be it furtherRESOLVED, That our AMA adopt as policy and urge that when health care facilities are evaluating surgical and medical devices that require sterilization, in addition to effectiveness of the device for best patient outcomes, that facilities also be required to prioritize the modes of sterilization for the highest degree of worker and environmental safety. (New HOD Policy) |
| E | Res. 508 | Benzodiazepine and Opioid WarningNew YorkRESOLVED, That our American Medical Association raise the awareness of its members of the increased use of illicit sedative/opioid combinations leading to addiction and overdose death (Directive to Take Action); and be it furtherRESOLVED, That our AMA warn members and patients about this public health problem. (Directive to Take Action) |
| E | Res. 509 | Addressing Depression to Prevent Suicide EpidemicInternational Medical Graduates SectionRESOLVED, That our American Medical Association collaborate with the Centers for Disease Control and Prevention (CDC), the National Institute of Health (NIH) and other stakeholders to increase public awareness about symptoms, early signs, preventive and readily available therapeutic measures including antidepressants to address depression and suicide; (Directive to Take Action) and be it furtherRESOLVED, That our AMA work with the CDC, the NIH and encourage other specialty and state medical societies to work with their members to address the epidemic of depression and anxiety disorder and help to prevent death by suicide by promoting services to screen, diagnose and treat depression. (Directive to Take Action) |
| E | Res. 510 | The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) InitiativeResident and Fellow SectionRESOLVED, That our American Medical Association support initiatives to improve and reduce the barriers to the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening clinical indications. (New HOD Policy) |
| E | Res. 511 | Mandating Critical Congenital Heart Defect Screening in NewbornsResident and Fellow SectionRESOLVED, That our American Medical Association support screening for critical congenital heart defects for newborns following delivery prior to hospital discharge. (New HOD Policy) |
| E | Res. 512 | Fertility Preservation in Pediatric and Reproductive Aged Cancer PatientsResident and Fellow SectionRESOLVED, That our American Medical Association encourage disclosure to cancer patients on risks to fertility when gonadotoxicity due to cancer treatment is a possibility (New HOD Policy); and be it furtherRESOLVED, That our AMA support education for providers who counsel patients that may benefit from fertility preservation. (New HOD Policy) |
| E | Res. 513 | Determining Why Infertility Rates Differ Between Military and Civilian WomenWomen Physicians SectionRESOLVED, That our American Medical Association advocate for additional research to better understand whether higher rates of infertility in service women may be linked to military service and which approaches might reduce the burden of infertility among service women. (Directive to Take Action) |
| E | Res. 514 | Opioid AddictionAmerican Medical Women's AssociationRESOLVED, That our American Medical Association work with constituent organizations to assure that women of child-bearing age who are using opioids and are accessing the health care system undergo evaluation for pregnancy and, if pregnancy, be offered prenatal care (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate that women who use opioids prior to caesarian section are offered multi-modalities to control pain and improve function after the procedure with the goal of transitioning to other methods of pain control for long term (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with hospitals and relevant constituent organizations to assure that the enhanced recovery after surgery protocol for caesarian section is widely adopted to optimize recovery and improve function while decreasing use of opioid medications for pain, especially given the impact of such use in breast-feeding mothers and their infants. (Directive to Take Action) |
| E | Res. 515 | Reversing Opioid EpidemicAmerican Medical Women's AssociationRESOLVED, That our American Medical Association include in their program, Reversing the Opioid Epidemic, education materials for physicians regarding sex-based differences in perception of pain, including the impact of co-morbid conditions, sex-based differences in response to opioids and risks for opioid addiction, and issues with accessing and outcomes of addiction programs among women. (Directive to Take Action) |
| E | Res. 516 | Alcohol Consumption and HealthAmerican Society of Clinical OncologyRESOLVED, That our American Medical Association recognize alcohol consumption as well as alcohol abuse as a modifiable risk factor for cancer (New HOD Policy); and be it furtherRESOLVED, That our AMA support research and educational efforts about the connection between alcohol consumption and several types of cancer (New HOD Policy); and be it furtherRESOLVED, That our AMA amend policy H-425.993, “Health Promotion and Disease Prevention,” by addition and deletion to read as follows:“…(4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol consumption, ~~abuse,~~ particularly that which leads to illness, cancer, and accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits…” (Modify Current HOD Policy) |
| E | Res. 517# | CompoundingAmerican Academy of DermatologyRESOLVED, That our American Medical Association provide a 50-state analysis of state law requirements governing in-office preparation of medications in physicians’ offices, including which states have adopted USP Chapter 797 and how compounding is defined by state law (Directive to Take Action); and be it furtherRESOLVED, That our AMA oppose any state medical board action to delegate authority or oversight of physicians preparing medications in physicians’ offices to another regulatory body (e.g., state pharmacy board) (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with medical specialty societies to preserve a physician’s ability to prepare medications in physicians’ offices and be able to do so without being subject to unreasonable and burdensome equipment and process requirements. (Directive to Take Action) |
| E | Res. 518# | Chemical Variability in Pharmaceutical ProductsAmerican College of CardiologyRESOLVED, That our American Medical Association do a study and report back by the 2019 Interim Meeting regarding the pharmaceutical variability, both in API and dissolution, the impact on patient care and make recommendations for action from their report findings (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for legislation requiring independent testing and verification of the chemical content of batches of pharmaceuticals (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for the logging of batches at the patient level, so the batches can be traced and connected to patient outcomes or adverse events. (Directive to Take Action) |
| E | Res. 519# | Childcare Availability for Persons Receiving Substance Use Disorder TreatmentMichiganRESOLVED, That our American Medical Association support the implementation of childcare resources in existing substance use treatment facilities and acknowledge childcare infrastructure and support as a major priority in the development of new substance use programs. (New HOD Policy) |
| E | Res. 520# | Substance Use During PregnancyMichiganRESOLVED, That our American Medical Association amend policy H-420.950, “Substance Use Disorders During Pregnancy,” by addition as follows:Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse; ~~and~~ (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy~~.~~; and (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without an evaluation from a social worker. (Modify Current HOD Policy) |
| E | Res. 521# | Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy CounterMichiganRESOLVED, That our American Medical Association work with national pharmacy chains to move inhaled epinephrine (Primatene Mist HFA) behind the counter. (Directive to Take Action) |
| E | Res. 522# | Improved Deferral Periods for Blood DonorsMichiganRESOLVED, That our American Medical Association amend AMA policy H-50.973, “Blood Donor Deferral Criteria,” by addition and deletion to read as follows:Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on the scientific literature; ~~and~~ (3) supports a blood donation deferral period for men who have sex with men that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood donation. (Modify Current HOD Policy) |
| E | Res. 523# | Availability and Use of Low Starting Opioid DosesMichiganRESOLVED, That our American Medical Association reaffirm AMA Policies D-160.981, D 120.947, D-120.976, and D-120.971 to ensure the dissemination of educational materials for physicians on options for prescribing the lowest effective dosage, such as hydrocodone 2.5 mg or oxycodone 2.5 mg with acetaminophen, for patients who need an initial prescription for an oral narcotic and work with pharmacies and other relevant stakeholders to ensure lower dosage options are stocked and available at prices that do not exceed that of the same narcotic at a higher dosage. (Reaffirm HOD Policy) |
| E | Res. 524# | Availability of Naloxone BoxesMichiganRESOLVED, That our American Medical Association support the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription; and be it further (New HOD Policy)RESOLVED, That our AMA amend Policy H-95.932, “Increasing Availability of Naloxone,” by addition and deletion as follows:1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. 2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone. 3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients. 4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing. 5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law. 6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively. 7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration. 8. Our AMA ~~urges the Food and Drug Administration to study the practicality and utility of~~ supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators. (Modify Current HOD Policy) |
| E | Res. 525# | Support for Rooming-in of Neonatal Abstinence Syndrome Patients with their ParentsMedical Student SectionRESOLVED, That our American Medical Association support keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient’s health and safety permits, through the implementation of rooming-in programs (New HOD Policy); and be it furtherRESOLVED, That our AMA support the education of physicians about rooming-in patients with neonatal abstinence syndrome. (New HOD Policy) |
| E | Res. 526# | Trauma-Informed Care Resources and SettingsMedical Student SectionRESOLVED, That our American Medical Association recognize trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization (New HOD Policy); and be it furtherRESOLVED, That our AMA support trauma-informed care in all settings, including but not limited to clinics, hospitals, and schools, by directing physicians and medical students to evidenced-based resources. (New HOD Policy) |
| E | Res. 527# | Increasing the Availability of Bleeding Control SuppliesMedical Student SectionRESOLVED; That AMA Policy H-130.935 be amended by addition to read as follows:H-130.935 Support for Hemorrhage Control Training1. Our AMA encourages state medical and specialty societies to promote thetraining of both lay public and professional responders in essential techniques ofbleeding control.2. Our AMA encourages, through state medical and specialty societies, theinclusion of hemorrhage control kits (including pressure bandages, hemostaticdressings, tourniquets and gloves) for all first responders.3. Our AMA supports the increased availability of bleeding control supplies in schools, places of employment, and public buildings. (Modify Current HOD Policy) |
| E | Res. 528# | Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography ViewingMedical Student SectionRESOLVED, 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. (New HOD Policy) |
| E | Res. 529# | Adverse Impacts of Delaying the Implementation of Public Health RegulationsMedical Student SectionRESOLVED, That our American Medical Association urge the Environmental Protection Agency and other federal regulatory agencies to enforce pesticide regulations, particularly of restricted use pesticides, that safeguard human and environmental health, especially in vulnerable populations including but not limited to agricultural workers, immigrant migrant workers, and children (Directive to Take Action); and be it furtherRESOLVED, That our AMA analyze ongoing regulation delays that impact public health, as deemed appropriate. (Directive to Take Action) |
| E | Res. 530# | Implementing Naloxone Training into the Basic Life Support (BLS) Certification ProgramNew JerseyRESOLVED, That our American Medical Association collaborate with the Occupational Safety and Health Administration and state medical societies to include naloxone rescue kits in first aid equipment. (Directive to Take Action) |
| E | Res. 531\* | Support for Children of Incarcerated ParentsMedical Student SectionRESOLVED, That our American Medical Association support legislation and initiatives that provide resources and support for children of incarcerated parents. (New HOD Policy) |
| E | Res. 532\* | Dispelling Myths of Bystander Opioid OverdoseYoung Physicians SectionRESOLVED, That our American Medical Association work with appropriate stakeholders to develop and disseminate educational materials aimed at dispelling the fear of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives (Directive to Take Action); and be it further RESOLVED, That our AMA work with appropriate stakeholders to identify those professions, such as first responders, most impacted by opioid overdose deaths in order to provide targeted education to dispel the myth of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives. (Directive to Take Action)  |
| F | BOT 01 | Annual ReportThe Consolidated Financial Statements for the years ended December 31, 2018 and 2017 and the Independent Auditor’s report have been included in a separate booklet, titled “2018 Annual Report.” This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing. |
| F | BOT 04 | AMA 2020 DuesThe Board of Trustees recommends no change to the dues levels for 2020, that the following be adopted and that the remainder of this report be filed:Regular Members $420Physicians in Their Second Year of Practice $315Physicians in Military Service $280Physicians in Their First Year of Practice $210Semi-Retired Physicians $210Fully Retired Physicians $84Physicians in Residency Training $45Medical Students $20 |
| F | BOT 10 | Conduct at AMA Meetings and Events1. That Policy D-140.954, “Harassment Issues Within the AMA,” be rescinded as having been fulfilled by the report. (Rescind HOD Policy)2. That Policy H-140.837, “Anti-Harassment Policy,” be renamed “Policy on Conduct at AMA Meetings and Events” and further amended by insertion and deletion as follows (Modify Current HOD Policy):**~~Anti-Harassment Policy Applicable to AMA Entities~~****Policy on Conduct at AMA Meetings and Events**It is the **policy** of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.~~a~~Any type of harassment of any attendee of an AMA ~~staff, fellow delegates or others by members of the House of Delegates or~~ hosted meeting, event and other ~~attendees at or in connection with HOD meetings, or otherwise~~ activity, including but not limited to dinners, receptions and social gatherings held in conjunction with ~~HOD meetings,~~ an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA ~~delegates and staff are conducting AMA~~ business is conducted. This zero tolerance **policy** also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.**Definition**Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise ~~protected group status~~, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.**Sexual Harassment**Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this **policy**, sexual harassment includes:- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual’s work performance, by instances of such conduct.Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual’s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.**Operational Guidelines**The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:*1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)*The Office of General Counsel will appoint a “Conduct Liaison” for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.*2. Reporting Violations of the Policy*Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.These reporting mechanisms will be publicized to ensure awareness.*3. Investigations*All reported violations of Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA’s Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).*4. Disciplinary Action*If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:- Prohibiting the violator from attending future AMA events or activities;- Removing the violator from leadership or other roles in AMA activities;- Prohibiting the violator from assuming a leadership or other role in future AMA activities;- Notifying the violator’s employer and/or sponsoring organization of the actions taken by AMA;- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;- Referral to law enforcement.The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).*5. Confidentiality*All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.*6. Assent to Policy*As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.~~1. Reporting a complaint of harassment~~~~Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.~~~~Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy~~~~H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.~~~~Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.~~~~2. Investigations~~~~Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.~~~~3. Disciplinary Action~~~~If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.~~~~If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.~~~~If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.~~~~If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.~~~~4. Confidentiality~~~~To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.~~ |
| F | BOT 12 | Data Used to Apportion DelegatesA. That Policy G-600.016, “Data Used to Apportion Delegates,” be amended to read as follows:1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review ~~and state medical society~~ of its current AMA membership count ~~status report~~. (New HOD Policy)2. “Pending members” will be added to the number of active AMA members in theDecember 31 count for the purposes of AMA delegate allocations to ~~national medical specialty and~~ state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity. (New HOD Policy)~~3. Our AMA Physician Engagement department will develop a mechanism to prevent a second counting of those previous “pending members” at the end of the following year until their membership has been renewed. (Directive to Take Action)~~3. Our AMA will track “pending members” from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year. (New HOD Policy)4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy. (Directive to Take Action)B. That the Council on Constitution and Bylaws prepare a report for the 2019 Interim Meeting that will allow the implementation of Policy G‑600.016, as amended herein. |
| F | BOT 24 | Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership PromotionThrough the analysis that led to this report, an opportunity was identified to improve AMA member benefits for direct licensees with 25 or fewer users by increasing their discount to 30%. This change will go into effect for the 2020 CPT data file. The increased discount will enable the AMA to continue to support its mission, while having a positive impact on AMA members in small practices. This is also consistent with other AMA Membership discount programs.Consequently, the Board of Trustees recommends that Resolution 607-A-18 not be adopted and that the remainder of this report be filed. |
| F | BOT 27 | Advancing Gender Equity in Medicine1. That our American Medical Association adopt the following language as policy, “Principles for Advancing Gender Equity in Medicine”:Our AMA:1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;3. endorses the principle of equal opportunity of employment and practice in the medical field;4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;5. acknowledges that mentorship and sponsorship are integral components of one’s career advancement, and encourages physicians to engage in such activities;6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas. (New HOD Policy)2. That our AMA rescind the following policies, as they have been incorporated into the “Principles for Advancing Gender Equity in Medicine”:a. D-200.981, “Gender Disparities in Physician Income and Advancement”b. H-525.992, “Women in Medicine”c. H-65.968, “Equal Opportunity” (Rescind HOD Policy)3. That our AMA rescind AMA Policy D-65.989 (1), “Advancing Gender Equity in Medicine,” as this report has fulfilled the request for information on positions and recommendations regarding gender equity in medicine, including the development of clarifying principles. (Rescind HOD Policy)4. That our AMA encourage state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine. (Directive to Take Action)5. That our AMA encourage academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. (Directive to Take Action)6. That our AMA, modify Policy D-65.989, “Advancing Gender Equity in Medicine,” and continue to: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral ~~objective~~ criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement. (Modify HOD Policy)7. That our AMA amend AMA Policy G-600.035, “The Demographics of the House of Delegates,” to read as follows:a. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.b. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year.c. Future reports on the demographic characteristics of the House of Delegates should, whenever possible, ~~will~~ identify and include information on successful initiatives and best practices to promote diversity within~~,~~ ~~particularly by age,~~ state and specialty society delegations. (Modify Current HOD Policy) |
| F | ComRpt  | Report of the House of Delegates Committee on Compensation of the OfficersThe Committee on Compensation of the Officers recommends the following recommendations be adopted and the remainder of this report filed:1. That Policy D-605.990 be appended by a new section XXIII as follows:

Annual Health Insurance Stipend (“Stipend”)The purpose of this payment is to provide a Health Insurance Stipend (Stipend) to compensate the President, President-Elect, and Immediate Past President when the President(s) lose(s) his/her Employer provided medical insurance coverage. President(s) who lose his/her Employer insurance will substantiate his/her eligibility for the Stipend by written notice to the Board Chair detailing the effective date of the loss of coverage and listing covered family members. The President receiving the Stipend will have the sole discretion to determine the appropriate health insurance for himself/herself and the family members; however, the Stipend will be calculated based on 70% of the then current Gold Plan premium for his/her state/county of residence.Should a President become Medicare eligible during his/her term(s), the Stipend will end for the President the month Medicare coverage begins. If the President has covered family members who are not Medicare eligible, the amount of the Stipend will be adjusted to cover only those family members until they become Medicare eligible. As family members become Medicare eligible, the President is expected to provide written notice of the event to the Board Chair and the Stipend will be adjusted accordingly the month Medicare coverage begins.In any case, the Stipend will end the sooner the President(s) obtains other health insurance coverage or the month following the end of his/her term as Immediate Past President.Should a President have health insurance coverage through Medicare when elected, he/she will not be eligible for the Stipend for themselves or family members.The amount of the Stipend will be 70% of the then current Gold Plan premium in the President(s) state/county of residence for each covered family member. If there are multiple Gold Plans in the state/county, the Stipend will be based on the average of the then current Gold Plan premiums. The amount of the Stipend will be updated January 1 of each Plan year based on then Gold Plan premiums and covered family members.The Stipend will be paid monthly. The amount of the Stipend will be reported as taxable income for the President each calendar year and will be included in this Committee’s annual report to the House which documents compensation paid to Officers and the IRS reported taxable value of benefits, perquisites, services, and in-kind payments.1. Except as noted above, there will be no other changes to the Officers compensation for the period beginning July 1, 2019. (Directive to Take Action)
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| F | Res. 601 | AMA Policy Statement with EditorialsIndianaRESOLVED, That 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. 602 | Expectations for Behavior at House of Delegates MeetingsSusan R. Bailey, MD, Delegate; and Bruce A. Scott, MD, DelegateRESOLVED, That every AMA HOD delegate and alternate delegate shall, as a condition to receiving their credentials for any AMA HOD meeting, acknowledge and accept during the AMA HOD meeting registration process (i) AMA policies concerning conduct at AMA HOD meetings and (ii) applicable adjudication and disciplinary processes for violations of such policies (New HOD Policy); and be it furtherRESOLVED, That any AMA HOD delegate or alternate delegate who knowingly fails to acknowledge and accept during the AMA HOD meeting registration process (i) AMA policies concerning conduct at AMA HOD meetings and (ii) applicable adjudication and disciplinary processes for violations of such policies shall not be credentialed as a delegate or alternate delegate at that meeting. (New HOD Policy) |
| F | Res. 603 | Creation of an AMA Election Reform CommitteeConnecticutRESOLVED, That our American Medical Association appoint a House of Delegates Election Reform Committee to examine ways to expedite and streamline the current election and voting process for AMA officers and council positions (Directive to Take Action); and be it furtherRESOLVED, 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 (Directive to Take Action); and be it furtherRESOLVED, That our AMA review the methods to reduce and control the cost of campaigns (Directive to Take Action); and be it furtherRESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019 Interim Meeting with a list of recommendations. (Directive to Take Action)  |
| F | Res. 604 | Engage and Collaborate with The Joint CommissionIllinoisRESOLVED, That our American Medical Association study and report back on any potential impact, influence, or conflicts of interest related to unrestricted grants from pharmaceutical and medical device manufacturers on the development of Joint Commission accreditation standards (especially those that relate to medical prescribing, procedures, and clinical care by licensed physicians). (Directive to Take Action) |
| F | Res. 605 | State Societies and the AMA Litigation CenterNew YorkRESOLVED, That when seeking a state medical society’s support of an amicus brief on a legal matter, especially one pertaining to an issue in that state, the American Medical Association Litigation Center consider the state medical society’s point of view in developing the argument, and maintain full disclosure during the drafting of the amicus or any change in strategy. (Directive to Take Action) |
| F | Res. 606 | Investigation into Residents, Fellows, and Physician UnionsResident and Fellow SectionRESOLVED, That our American Medical Association study the feasibility of a national house-staff union to represent all interns, residents and fellows. (Directive to Take Action) |
| F | Res. 607 | Re-Establishment of National Guideline ClearinghouseAmerican Society of Clinical OncologyRESOLVED, That our American Medical Association reaffirm Policy H-410.965, “Clinical Practice Guidelines, Performance Measures, and Outcomes Research Activities” (Reaffirm HOD Policy); and be it furtherRESOLVED, That our AMA research possible and existing alternatives for the functions of the National Guidelines Clearinghouse with a report back to the House of Delegates. (Directive to Take Action) |
| F | Res. 608 | Financial Protections for Doctors in TrainingResident and Fellow SectionRESOLVED, That our American Medical Association support retirement plans for all residents and fellows, which includes retirement plan matching in order to further secure the financial stability of physicians and increase financial literacy during training (New HOD Policy); and be it furtherRESOLVED, That our AMA support that all programs provide financial advising to resident and fellows. (New HOD Policy) |
| F | Res. 609 | Update to AMA Policy H-525.998, Women in Organized MedicineWomen Physicians SectionRESOLVED, That our AMA amend AMA Policy H-525.998, “Women in Organized Medicine,” by deletion to read as follows:Our AMA:(1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession;(2) supports the concept of increased tax benefits for working parents;(3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings; and(4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs.~~; and~~ ~~(5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site.~~ (Modify HOD Policy) |
| F | Res. 610 | Mitigating Gender Bias in Medical ResearchIllinoisRESOLVED, That our American Medical Association advocate for the establishment of best practices that remove any gender bias from the review and adjudication of grant applications and submissions for publication in peer-reviewed journals, including removing names and gender identity from the applications or submissions during the review process. (Directive to Take Action) |
| F | Res. 611# | Election ReformRadiological Society of North AmericaRESOLVED, That our American Medical Association create a speaker-appointed task force to re-examine election rules and logistics including regarding social media, emails, mailers, receptions and parties, ability of candidates from smaller delegations to compete, balloting electronically, and timing within the meeting, and report back recommendations regarding election processes and procedures to accommodate improvements to allow delegates to focus their efforts and time on policy-making (Directive to Take Action); and be it furtherRESOLVED, That our AMA’s speaker-appointed task force consideration should include addressing (favorably or unfavorably) the following ideas:a) Elections being held on the Sunday morning of the annual and interim meetings of the House of Delegates.b) Coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously.c) Separating the logistical election process based on the office (e.g. larger interview session for council candidates, more granular process for other offices)d) An easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail.e) Electronic balloting potentially using delegates’ personal devices as an option for initial elections and runoffs in order to facilitate timely results and minimal interruptions to the business.f) Seeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process.g) Address the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g. vote trading, block voting, etc.) (Directive to Take Action); and be it furtherRESOLVED, That the task force report back to the HOD at the 2019 Interim meeting. (Directive to Take Action) |
| F | Res. 612# | Request to AMA for Training in Health Policy and Health LawNew MexicoRESOLVED, That our American Medical Association offer its members training in health policy and health law, and develop a fellowship in health policy and health law. (Directive to Take Action) |
| F | Res. 613# | Language Proficiency Data of Physicians in the AMA MasterfileMinority Affairs SectionRESOLVED, That our American Medical Association initiate collection of self-reported physician language proficiency data in the Masterfile by asking physicians with the validated six-point adapted ILR-scale for physicians to indicate their level of proficiency for each language besides English in the healthcare settings. (Directive to Take Action) |
| F | Res. 614# | Racial and Ethnic Identity Demographic Collection by the AMAMinority Affairs SectionRESOLVED, That our American Medical Association develop a plan with input from the Minority Affairs Section and the Chief Health Equity Officer to consistently include racial and ethnic minority demographic information for physicians and medical students. (Directive to Take Action) |
| F | Res. 615# | Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare LeadershipMedical Student SectionRESOLVED, That our American Medical Association change existing automatic paper JAMA subscriptions to opt-in paper subscriptions by the year 2020, while preserving the option to receive paper JAMA, in order to support broader climate change efforts. (Directive to Take Action) |
| F | Res. 616# | TIME’S UP HealthcareMinority Affairs SectionRESOLVED, That our American Medical Association evaluate TIME’S UP Healthcare program and consider participation as a TIME’S UP partner in support of our mutual objectives to eliminate harassment and discrimination in medicine with report back at the 2019 Interim Meeting. (Directive to Take Action) |
| F | Res. 617# | Disabled Physician AdvocacyConnecticutRESOLVED That our American Medical Association study and report back on eliminating stigmatization and enhancing inclusion of disabled physicians including but not limited to:1) Enhancing representation of disabled physicians within the AMA.2) Examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA (Directive to Take Action); and be it furtherRESOLVED That our AMA identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable disabled physicians to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration. (Directive to Take Action) |
| F | Res. 618\* | Stakeholder Input to Reports of the House of DelegatesIntegrated Physician Practice SectionRESOLVED, That our American Medical Association study and propose a process for interested stakeholders represented in the House of Delegates to view an online list of AMA Council and Board reports under development and a mechanism for stakeholder input on draft reports, and report back at the 2019 Interim Meeting. (Directive to Take Action) |
| G | BOT 13 | Employed Physician Bill of Rights and Basic Practice Professional Standards1. That our AMA reaffirm the following policies:H-225.950, AMA Principles for Physician Employment,H-225.997, Physician-Hospital Relationships,H-225.942, Physician and Medical Staff Member Bill of Rights,H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information,H-300.982, Maintaining Competence of Health Professionals, andH-383.998, Resident Physicians, Unions and Organized Labor. (Reaffirm HOD Policy)2. That our AMA amend policy H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information:“(1)(a) Physicians should be required to disclose personal financial information to the hospital/health system only if they are serving or being considered to serve as a member of the governing body, as a corporate officer, or as an employee/contractor of the hospital/health system; and such information should be used only so that other individuals understand what conflicts may exist when issues are discussed and when recusal from voting or discussion on an issue may be appropriate.” (Modify Current HOD Policy)3. That our AMA amend policy H-225.950, AMA Principles for Physician Employment:“(1)(b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.” (Modify Current HOD Policy)4. That our AMA advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients. (New HOD Policy) |
| G | BOT 15 | Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization1. That our American Medical Association reaffirm the following policies:H-170.986, “Health Information and Education”H-405.957, “Programs on Managing Physician Stress and Burnout;”H-405.961, “Physician Health Programs;”D-405.990, “Educating Physicians About Physician Health Programs;”H-95.955, “Physician Impairment;” andH-295.858, “Access to Confidential Health Services for Medical Students and Physicians.” (Reaffirm HOD Policy)2. That our American Medical Association amend existing Policy H-405.961, “Physician Health Programs,” to add the following directive (Modify Current HOD Policy):1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.2. Our AMA encourages state medical societies to collaborate with the state medical boards to a) develop strategies to destigmatize physician burnout, and b) encourage physicians to participate in the state’s physician health program without fear of loss of license or employment.3. That our AMA amend existing Policy D-310.968, “Physician and Medical Student Burnout,” to add the following directives (Modify Current HOD Policy):1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify factors that may lead to physician demoralization.8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (2) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being. |
| G | BOT 31 | Non-Payment and Audit Takebacks by CMSThe Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 704-A-18 and the remainder of the report be filed:That our American Medical Association advocate to oppose claim nonpayment, extrapolation of overpayments, and bundled payment denials based on minor wording or clinically insignificant documentation inconsistencies. (New HOD Policy) |
| G | BOT 32 | Impact of High Capital Costs of Hospital EHRs on the Medical StaffThe Board of Trustees recommends that Policy D-225.974, “Impact of the High Capital Cost of Hospital EHRs on the Medical Staff,” be rescinded as having been fulfilled by this report and that the remainder of this report be filed. (Rescind HOD Policy) |
| G | CMS 07 | Hospital Consolidation1. That our American Medical Association (AMA) affirm that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority. (New HOD Policy)2. That our AMA continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency. (New HOD Policy)3. That our AMA encourage state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices. (New HOD Policy)4. That our AMA reaffirm Policy H-215.969, which provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. (Reaffirm HOD Policy)5. That our AMA reaffirm Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation, and that each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body. (Reaffirm HOD Policy)6. That our AMA reaffirm Policy H-225.950, which outlines AMA Principles for Physician Employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations, and that discourage physicians from entering into agreements that restrict their right to practice medicine for a specified period of time or in a specified area upon termination of employment. (Reaffirm HOD Policy) and7. That our AMA reaffirm Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy. (Reaffirm HOD Policy) |
| G | CMS 08 | Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor1. That our American Medical Association (AMA) reaffirm Policy H-125.986 supporting efforts to ensure that reimbursement policies established by pharmaceutical benefit managers (PBMs) are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications (Reaffirm HOD Policy)2. That our AMA reaffirm Policy H-110.992 stating that the AMA will monitor the relationships between PBMs and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Reaffirm HOD Policy)3. That our AMA reaffirm Policy H-100.956 calling for collaboration with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs (Reaffirm HOD Policy)4. That our AMA renew efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the Group Purchasing Organization and PBMs anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages. (New HOD Policy)5. That our AMA support efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages. (New HOD Policy) |
| G | CMS 09 | Health Plan Payment of Patient Cost-SharingThe Council on Medical Service recommends that the following be adopted in lieu of Resolution 707-A-18 and the remainder of the report be filed:1. That our American Medical Association (AMA) reaffirm Policies H-165.985 and H-165.838 illustrating the AMA’s commitment to the business freedom of physician practices. (Reaffirm HOD Policy)2. That our AMA reaffirm Policy H-165.849 stating that the AMA will continue to engage in ongoing dialogue with health insurers and health insurance representatives about the increasing difficulty of practices in collecting co-payments and deductibles. (Reaffirm HOD Policy)3. That our AMA reaffirm Policy H-165.828 encouraging the development of demonstration projects to allow individuals who forego cost-sharing subsidies by enrolling in a bronze plan to have access to a partially-funded health savings account and supporting additional education regarding deductibles and cost-sharing at the time of health plan enrollment. (Reaffirm HOD Policy)4. That our AMA amend Policy D-190.974 by addition and deletion as follows:Administrative Simplification in the Physician Practice1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.6. Our AMA will continue its efforts ~~expand its Heal the Claims process(TM) campaign as necessary~~ to ensure that physicians are aware of the value of automating their claims cycle. (Modify Current HOD Policy)5. That our AMA support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations. (New HOD Policy)6. That our AMA encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability. (New HOD Policy) |
| G | CMS 10 | Alternative Payment Models and Vulnerable Populations1. That our American Medical Association (AMA) support alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities. (New HOD Policy)2. That our AMA continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations. (New HOD Policy)3. That our AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician’s control. (New HOD Policy)4. That our AMA reaffirm Policy H-385.913 stating that APMs should limit physician accountability to aspects of spending and quality that they can reasonably influence; APMs should understand their patient populations, including non-clinical factors; and support new data sources that enable adequate analyses of clinical and non-clinical factors that contribute to a patient’s health and success of treatment. (Reaffirm HOD Policy)5. That our AMA reaffirm Policy H-385.908 stating that the AMA should continue advocating for APMs limiting the financial risk requirements to costs that physicians participating in an APM have the ability to control or influence and work with stakeholders to design risk adjustment systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient’s health and success of treatment, such as severity of illness, access to health care services, and socio-demographic factors. Moreover, Policy H-385.908 recognizes that technology should enable the care team and states that the AMA should work with stakeholders to develop information technology (IT) systems that support and streamline clinical participation and enable IT systems to support bi-directional data exchange. (Reaffirm HOD Policy)6. That our AMA reaffirm Policy H-350.974 recognizing that racial and ethnic health disparities is a major public health problem, stating that the elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA, and supporting education and training on implicit bias, diversity, and inclusion. (Reaffirm HOD Policy)7. That our AMA reaffirm Policy D-35.985 supporting physician-led, team-based care recognizing that interdisciplinary physician-led care teams are well equipped to provide a whole-person health care experience. (Reaffirm HOD Policy)8. That our AMA reaffirm Policy D-350.995 promoting diversity within the workforce as one means to reduce disparities in health care. (Reaffirm HOD Policy)9. That our AMA reaffirm Policy H-440.828 on community health workers (CHWs) recognizing that they play a critical role as bridgebuilders between underserved communities and the health care system and calling for sustainable funding mechanisms to financial CHW services. (Reaffirm HOD Policy)10. That our AMA reaffirm Policy H-450.924 supporting that hospital program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and physicians that exacerbate health care disparities. (Reaffirm HOD Policy)11. That our AMA reaffirm Policy H-280.945 supporting better integration of health care and social services and supports. (Reaffirm HOD Policy)12. That our AMA reaffirm Policy H-160.896 calling to expand payment reform proposals that incentivize screening for social determinants of health and referral to community support systems. (Reaffirm HOD Policy) |
| G | CMS 11 | Corporate Investors1. That our American Medical Association (AMA) reaffirm Policy H-215.981, which opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. (Reaffirm HOD Policy)2. That our AMA reaffirm Policy H-225.950, which affirms that a physician’s paramount responsibility is to his or her patients, and which outlines principles related to conflicts of interest and contracting. (Reaffirm HOD Policy)3. That our AMA reaffirm Policy H-285.951, which states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of medical care. (Reaffirm HOD Policy)4. That our AMA reaffirm Policy H-160.960, which states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or the physician. (Reaffirm HOD Policy)5. That our AMA encourage physicians who are contemplating corporate investor partnerships to consider the following guidelines:a. Physicians should consider how the practice’s current mission, vision, and long-term goals align with those of the corporate investor.b. Due diligence should be conducted that includes, at minimum, review of the corporate investor’s business model, strategic plan, leadership and governance, and culture.c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships. (New HOD Policy)6. That our AMA support improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices. (New HOD Policy)7. That our AMA encourage national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty. (New HOD Policy)8. That our AMA rescind Policy D-383.979, which requested this report. (Rescind HOD Policy) |
| G | Res. 701 | Coding for Prior Authorization ObstaclesDelawareRESOLVED, That our American Medical Association support the establishment of ICD codes that cover and fully describe prior authorization processes and any and all other administrative and bureaucratic obstacles that may cause or in part contribute to a patient’s morbidity or mortality by both delay, as well as denial, of services. (New HOD Policy) |
| G | Res. 702 | Peer Support Groups for Second VictimsYoung Physicians SectionRESOLVED, That our American Medical Association encourage institutional, local, and state physician wellness programs to consider developing peer support groups to address the “second victim phenomenon” (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with other interested organizations to develop a survey of all physicians in the United States to quantitate the effects of stress and burnout on them, and its potential impact on our physician workforce. (Directive to Take Action) |
| G | Res. 703 | Preservation of the Patient-Physician RelationshipOrganized Medical Staff SectionRESOLVED, That our American Medical Association, in an effort to improve professional satisfaction among physicians while also enhancing patient care, conduct a study to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, as well as identify healthcare work environment factors that impact a physician’s ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter, and report back at the 2020 Interim Meeting. |
| G | Res. 704 | Prior Authorization ReformDelawareRESOLVED, That our American Medical Association explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens. (Directive to Take Action) |
| G | Res. 705 | Physician Requirements for Comprehensive Stroke Center DesignationThomas J. Madejski, MD, DelegateRESOLVED, That our American Medical Association advocate for changing the following two provisions from The Joint Commission Stroke Center Requirements:1) Stroke procedurists should not be required to perform 15 mechanical thrombectomies per year to qualify for taking endovascular call at designated stroke hospitals; and2) Stroke procedurists should be able to take call at more than one hospital at a time. (Directive to Take Action) |
| G | Res. 706 | Hospital Falls and “Never Events” - A Need for More in Depth StudyWisconsinRESOLVED, That our American Medical Association study the merits of recommending that “Patient death or serious injury associated with a fall while being cared for in a health care setting” be removed from the list of “Never Events” for which a hospital may face an adverse payment decision by third-party payors or an adverse accreditation decision by The Joint Commission (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the merits of recommending that a pay-for-performance measure be added which would reward health care organizations for taking steps resulting in patients' improved ability to participate in self-care, improved functional status, and improved mobility for seniors who have been admitted to a facility for a condition resulting in a temporary need for bed rest. (Directive to Take Action) |
| G | Res. 707 | Cost of Unpaid Patient Deductibles on Physician Staff TimeIllinoisRESOLVED, That our American Medical Association advocate for legislation that brings an end to insurance company practices that make it the physician’s responsibility to recoup patient out-of-pocket costs and deductibles created by health plans. (Directive to Take Action) |
| G | Res. 708# | Access to Psychiatric Treatment in Long-Term CareAmerican Association for Geriatric PsychiatryRESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services (CMS) to acknowledge that psychotropic medications can be an appropriate long-term care treatment for patients with chronic mental illness (Directive to Take Action); and be it furtherRESOLVED, That our AMA ask CMS to discontinue the use of psychotropic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications (Directive to Take Action); and be it furtherRESOLVED, That our AMA ask the CMS to acknowledge that antipsychotic medication can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed (Directive to Take Action); and be it furtherRESOLVED, That our AMA ask CMS to refrain from issuing citations or imposing financial penalties for the medically necessary and appropriate use of antipsychotic medication for the treatment of dementia-related psychosis. (Directive to Take Action) |
| G | Res. 709# | Promoting Accountability in Prior AuthorizationAmerican Association of Neurological SurgeonsRESOLVED, That AMA Policy H-320.968, “Approaches to Increase Payer Accountability,” be amended by addition and deletion as follows:Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)(2) Conduct of Review. Our AMA ~~supports~~ advocate for the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a utilization review entity or health plan be of the same specialty and have expertise to treat the medical condition or disease as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (Modify HOD Policy); and be it furtherRESOLVED, That the AMA and its Council on Judicial and Ethical Affairs, study the ethical and medicolegal responsibilities of physicians who participate in the prior authorization process on behalf of utilization review entities or health plans, particularly with regard to determinations of medical necessity, and report back to the HOD at the 2020 Annual Meeting with guidance for physicians who provide utilization review services. (Directive to Take Action) |
| G | Res. 710# | Council for Affordable Quality Healthcare AttestationMichiganRESOLVED, That our American Medical Association work with the Council for Affordable Quality Healthcare (CAQH) and any other relevant organizations to reduce the frequency of required CAQH reporting to twelve months or longer unless the physician has a change in relevant information to be updated. (Directive to Take Action) |
| G | Res. 711# | Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOsOrganized Medical Staff SectionRESOLVED, That our American Medical Association study: (1) the effect of hospital integrated system ACOs’ failure to generate savings on downsizing of the medical staff and further consolidation of medical practices; and (2) the root causes for failure to generate savings in hospital integrated ACOs, as compared to physician-owned ACOs, and report back at the 2019 Interim Meeting. (Directive to Take Action) |
| G | Res. 712# | Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save LivesSociety of Critical Care MedicineRESOLVED, That our American Medical Association collaborate with interested medical organizations such as the Centers for Disease Control and Prevention and the Society of Critical Care Medicine to promote the importance of early detection and expedited intervention of sepsis by healthcare providers who work in out-of-hospital settings to improve patient outcomes and save lives. (Directive to Take Action) |
| G | Res. 713\* | Selective Application of Prior AuthorizationAmerican College of RheumatologyRESOLVED, That our American Medical Association support policies such that prior authorization requirements will not be applied to items or services ordered by physicians and other health care practitioners:(i) whose prescribing or ordering practices align with an evidence-based guideline established or approved by a national professional medical association; or (ii) who meet quality (e.g. gold standard) criteria; or(iii) whose orders or prescriptions are routinely approved; or(iv) who adhere to a high quality clinical care pathway; or(v) who participate in an alternative payment model or care delivery model that aims to improve health care quality. (New HOD Policy) |
| G | Res. 714\* | Medicare Advantage Step TherapyAmerican College of RheumatologyRESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services (CMS) to immediately publish guidance to plans that lays out, at minimum, the patient safeguards proposed/finalized in the *Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses proposed rule* so that beneficiaries have some protections in 2019, as well as additional clarifying language on exceptions not limited to the following principles: 1. That the provider determines if a patient “fails” a treatment, not another entity such as the insurance company.2. Exception if the treatment is contraindicated.3. Exception if the provider determines the treatment is likely to be ineffective.4. Exception if the provider determines the treatment is likely to cause a harmful reaction. 5. Exception for those whose life could be in jeopardy or physical or sensory function irreparably harmed. 6. Exception if the provider and patient believe the treatment is likely to impede the patient’s ability to perform daily activities or responsibilities and/or adhere to the treatment plan.7. Clarification that a patient with a second eye event should be considered an established patient and therefore should not be subject to step therapy policies for the second eye event.8. Preclude any unwritten, implicit step therapy that is handled through a different utilization management process such as prior authorization.9. Provide adequate safeguards to maintain coverage for patients currently stable on a medication, even if the last dose was over 6 months prior (Directive to Take Action); and be it furtherRESOLVED, That if CMS does not respond to stakeholder input and publish guidance according to these and other principles, our AMA support and actively work to advance Congressional action to provide patients safeguards in the 2019 plan year. (Directive to Take Action) |
| G | Res. 715\* | Managing Patient-Physician Relations Within Medicare Advantage PlansTexasRESOLVED, That our American Medical Association advocate that Medicare Advantage plans allow a primary care physician to remove patients from his or her patient panel if the physician has proven he or she has been unable to establish a patient-physician relationship, despite multiple documented attempts (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate that physicians’ Healthcare Effectiveness Data and Information Set and other quality scores and ratings not be affected by patients with whom the physician has been unable to establish a patient-physician relationship. (Directive to Take Action) |
| G | Res. 716\* | Health Plan Claim Auditing ProgramsTexasRESOLVED, That our American Medical Association vigorously oppose the exclusive use of software or other methodologies, with no review of the patient’s medical record, to determine payment and/or denial of a claim based solely on the CPT codes, ICD-10 codes, and modifiers submitted on the claim (New HOD Policy); and be it furtherRESOLVED, That our AMA vigorously oppose the exclusive use of the patient’s medical claim history, with no review of the patient’s medical record, as a tool to deny or pay a claim (New HOD Policy); and be it furtherRESOLVED, That our AMA vigorously support the use of coding methods that adhere to CPT guidelines, rules, and conventions. (New HOD Policy) |
| G | Res. 717\* | Military Physician Reintegration into Civilian PracticeOrganized Medical Staff SectionRESOLVED, That our American Medical Association develop recommendations to inform local credentialing bodies of pathways to facilitate the process for military veteran physicians and surgeons to return to civilian practice without compromising patient care. (Directive to Take Action) |
| G | Res. 718\* | Economic Discrimination In The Hospital Practice SettingOrganized Medical Staff SectionRESOLVED, That our American Medical Association actively oppose policies that limit a physician’s access to hospital services based upon the number of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation. (New HOD Policy) |
| G | Res. 719\* | Interference with Practice of Medicine by the Nuclear Regulatory CommissionResident and Fellow SectionRESOLVED, That our American Medical Association advocate for a follow-up review by the Institute of Medicine of the Nuclear Regulatory Commission’s medical use program, specifically evaluating effects of the Nuclear Regulatory Commission’s regulatory policy in the last 25 years on the current state of nuclear medicine in the U.S. and patients’ access to care. (Directive to 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** |
|  **A = Reference Committee A** | **CEJA = Ethical and Judicial Affairs** |
|  **B = Reference Committee B** | **CLRPD = Long Range Planning and Development** |
|  **C = Reference Committee C** | **CME = Medical Education** |
|  **D = Reference Committee D** | **CMS = Medical Service** |
|  **E = Reference Committee E** | **CSAPH = Science and Public Health** |
|  **F = Reference Committee F** |  |
|  **G = Reference Committee G** |  |