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

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

| **Cmte\*** | **Item** | **Sponsor**† | **Title / Recommendations or Resolves** |
| --- | --- | --- | --- |
| .Con | BOT 17 | n/a | Specialty Society Representation in the House of Delegates - Five-Year ReviewThe Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:1. That the American College of Cardiology, American College of Chest Physicians, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine, American Medical Group Association and the National Association of Medical Examiners retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

That the American Medical Group Association be reclassified as a Professional Interest Medical Association (PIMA). (Directive to Take Action) |
| .Con | CCB 01  | n/a | Parity in our AMA House of DelegatesThe Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) 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.2.10 Registration and Seating 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.**2.10.6 National Medical Specialty Society or Professional Interest Medical Association President.** The current president of a national medical specialty society or a professional interest medical association may also be certified as an additional alternate delegate at the discretion of each national medical specialty society or professional interest medical association. |
| .Con | CCB 02  | n/a | Bylaw Consistency--Certification Authority for Societies represented in our AMA House of Delegates and Advance Certification for those SocietiesThe Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) 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.**2.1.4 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.**\*\*\*****2.2.4 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.**\*\*\*****2.3.4 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 Medical Student Region. Certification of delegates and alternate delegates must occur at least 30 days prior to the Annual Meeting of the House of Delegates.**\*\*\*****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.**2.10 Registration and Seating of Delegates.****\*\*\*****2.10.2 Credentials.** A delegate or alternate delegate 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~~ certification on file ~~signed by the president, secretary, or~~ ~~other authorized individual of the delegate’s or alternate delegate’s organization~~ stating 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~~ entity is established, and so certified to the AMA.**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~~ entity may appoint a substitute delegate or substitute alternate delegate, 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 place of that delegate 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 certification on file 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.~~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. |
| .Con | CCB 03  | n/a | AMA Delegation ApportionmentThe Council on Constitution and Bylaws recommends the following:1. That the following amendment to the AMA Bylaws be adopted. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.**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.**2.1.1 Apportionment.** The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.2.1.1.1 The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal. This Bylaw will sunset as of the close of business of the 2022 Interim Meeting unless the House of Delegates acts to retain it.[Subsequent bylaw provisions shall be renumbered] (Modify Bylaws)2. That Policy G-600.016(2) be amended by addition to read as follows:“Pending members” (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to 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. (Modify Current HOD Policy)3. That the remainder of this report be filed. |
| .Con | CEJA 01  | n/a | Competence, Self-Assessment and Self-AwarenessBased on the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills.However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:(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) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness.(g) Intervene in a timely, appropriate, and compassionate manner when a colleague’s ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician 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 | n/a | Amendment to E-1.2.2, “Disruptive Behavior by Patients”In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, “Discrimination against Physicians by Patients,” be rescinded; Opinion 1.2.2, “Disruptive Behavior by Patients,” be amended by addition and deletion as follows; and the remainder of this report be filed:The relationship between patients and physicians is based on trust and should serve to promote patients’ well-being while respecting ~~their~~ the dignity and rights of both patients and physicians.Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either physicians or patients can undermine trust and compromise the integrity of the patient-physician relationship. It can make members of targeted groups reluctant to seek or provide care, and create an environment that strains relationships among patients, physicians, and the health care team.Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those ~~they target~~ who are targeted.(b) Always treat patients with compassion and respect.(c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient’s behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.(d) In general, decline to accommodate patient requests for an alternative physician when the request is solely the product of prejudice against the physician’s personal characteristics.(e) Consider accommodating a patient’s request for an alternative physician when the request derives from the patient’s adverse personal experience, doing so would promote effective care, and another appropriately qualified physician is available to provide the needed care.(f) In emergency situations, patients who persist in opposing treatment from the physician assigned may be helped to seek care from other sources. When transfer is not feasible, patients should be informed that care will be provided by appropriately qualified staff independent of the patient’s expressed preference.(~~c~~g) Terminate the patient-physician relationship with a patient ~~who uses derogatory language or acts in a prejudiced manner~~ whose volitional behavior is disrespectful, derogatory, or prejudiced only if the patient will not modify the conduct. In such cases, the physician should arrange to transfer the patient’s care when that is feasible.Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:(h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.(i) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.(j) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients.(k) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community. |
| .Con | Res. 001 | MSS | Support for the Use of Psychiatric Advance DirectivesRESOLVED, That our American Medical Association support efforts to increase awareness and appropriate utilization of psychiatric advance directives. (New HOD Policy) |
| .Con | Res. 002 | MSS | Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB TrainingRESOLVED, That our American Medical Association work with appropriate stakeholders to support the creation of model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations. (Directive to Take Action) |
| .Con | Res. 003 | MSS | Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health DisparitiesRESOLVED, That our American Medical Association amend Policy H-315.996 by addition to read as follows:Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records, H-315.996The AMA advocates precision in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity. (Directive to Take Action) |
| .Con | Res. 004 | MSS | Improving Inclusiveness of Transgender Patients Within Electronic Medical Record SystemsRESOLVED, That our AMA amend Policy H-315.967, “Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation,” by addition and deletion to read as follows:Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H-315.967 Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, ~~and~~ preferred gender pronoun(s), preferred name, and an inventory of current anatomy 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, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will 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; (4) will 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; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians. (Modify Current HOD Policy) |
| .Con | Res. 005 | MSS | Removing Sex Designation from the Public Portion of the Birth CertificateRESOLVED, That our American Medical Association advocate for the removal of sex as a legal designation on the public portion of the birth certificate and that it be visible for medical and statistical use only. (Directive to Take Action) |
| .Con | Res. 006 | MSS | Transparency Improving Informed Consent for Reproductive Health ServicesRESOLVED, That our American Medical Association work with relevant stakeholders to establish a list of Essential Reproductive Health Services (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for legislation requiring healthcare organizations to clearly publish online and in points of service which Essential Reproductive Health Services are available at the organization along with any restrictions on Essential Reproductive Health Services at the institution, and include referral information to patients of other providers that cover the services within the same coverage area. (Directive to Take Action) |
| .Con | Res. 007 | MSS | Addressing the Racial Pay Gap in MedicineRESOLVED, That our American Medical Association support measures of racial pay awareness and the specific challenges that minority physicians face in regards to equal pay financial attainment (New HOD Policy); and be it further RESOLVED, That our AMA support efforts to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries and race of medical physicians. (New HOD Policy) |
| .Con | Res. 008\*\* | MSS | Improving the Health and Safety of Consensual Sex WorkersRESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work. (New HOD Policy)  |
| .Con | Res. 009 | Delegates | Data for Specialty Society Five-Year ReviewRESOLVED, That American Medical Association policy G-600.020, “Admission of Specialty Organizations to our AMA House,” item 6, be amended by addition and deletion to read as follows:The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, ~~have full voting privileges~~, and eligible to serve on committees or the governing body ~~hold office~~. (Modify Current HOD Policy)  |
| .Con | Res. 010 | Michigan | Ban Conversion Therapy of LGBTQ YouthRESOLVED, That our American Medical Association advocate for federal legislation to ban conversion therapy. (Directive to Take Action)  |
| .Con | Res. 011  | Michigan | End Child MarriageRESOLVED, That our American Medical Association oppose the practice of child marriage (New HOD Policy); and be it furtherRESOLVED, That our AMA advocate for the passage of state and federal legislation to end the practice of child marriage. (Directive to Take Action) |
| .Con | Res. 012\*\* | DC | Study of Forced Organ Harvesting by ChinaRESOLVED, That our American Medical Association gather and study all information available and possible on the issue of forced organ harvesting by China and issue a report to our House of Delegates at the 2020 Annual Meeting. (Directive to Take Action) |
| B | BOT 01 | n/a | Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)The Board recommends that our AMA amend Policy D-255.979, “Permanent Residence Status for Physicians on H1-B Visas,” by addition to read as follows, in lieu of Resolution 205-I-18 and that the remainder of the report be filed:Our AMA will work with all relevant stakeholders to: 1) clear the backlog for conversion from H1-B visas for physicians to permanent resident status, and 2) allow the children of H-1B visa holders, who have aged out of the H-4 non-immigrant classification, to remain in the U.S. legally while their parents’ green card applications are pending. (Modify Current HOD Policy) |
| B | BOT 02 | n/a | Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings 1. That our American Medical Association (AMA) support further research into how primary care practices can implement MAT into their practices and disseminate such research in coordination with primary care specialties; (New HOD Policy)2. That our AMA support efforts to expand primary care services to patients receiving methadone maintenance therapy (MMT) for patients receiving care in an Opioid Treatment Program or via office-based therapy; (New HOD Policy)3. That the AMA Opioid Task Force increase its evidence-based educational resources focused on MMT and publicize those resources to the Federation. (Directive to Take Action) |
| B | BOT 03 | n/a | Restriction on IMG MoonlightingThe Board recommends that our American Medical Association not adopt Resolution 204-I-18, “Restriction on IMG Moonlighting,” and that the remainder of the report be filed. |
| B | BOT 09 | n/a | Opioid Mitigation1. That our American Medical Association (AMA) encourage relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and that the AMA share that information with the Federation; (Directive to Take Action)2. That our AMA update model state legislation regarding needle and syringe exchange to state and specialty medical societies; (Directive to Take Action) 3. That our AMA amend Policy H-100.955, “Support for Drug Courts;”Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; ~~and~~ (2) encourages legislators to establish drug courts at the state and local level in the United States~~.~~; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy)4. That our AMA urge state and federal policymakers to enforce applicable mental health and substance use disorder parity laws; (Directive to Take Action)5. That our AMA reaffirm Policy H-95.932, “Increasing Availability of Naloxone;” and (Reaffirm HOD Policy)6. That our AMA reaffirm Policy D-95.981, “Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction.” (Reaffirm HOD Policy) |
| B | BOT 15 | n/a | Repealing Potential Penalties Associated with MIPS Resolution (206-I-18)Reducing the Regulatory Burden in Health Care (Resolution 231-I-18)Improving the Quality Payment Program and Preserving Patient Access (Resolution 243-A-19)The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 206-I-18, 231-I-18, and 243-A-19 and that the remainder of the report be filed:1. That our American Medical Association (AMA) support legislation that replaces or supplements the budget neutrality in MIPS with incentive payments.
2. That our AMA reaffirm Policy D-395.999, “Reducing MIPS Reporting Burden,” Policy D-395.998, “Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program,” Policy H-390.838, “MIPS and MACRA Exemption,” Policy D-390.950, “Preserving a Period of Stability in Implementation of the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act (MACRA),” Policy D-390.949, “Preserving Patient Access to Small Practices Under MACRA,” Policy H-385.913, “Physician-Focused Alternative Payment Models,” Policy H-385.913, “Physician-Focused Alternative Payment Models,” Policy H-450.931, “Moving to Alternative Payment Models,” and Policy H-385.908, “Physician-Focused Alternative Payment Models: Reducing Barriers.”
 |
| B | Res. 201 | MSS | Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation FacilitiesRESOLVED, That our American Medical Association advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care. (Directive to Take Action) |
| B | Res. 202 | MSS | Support for Veterans CourtsRESOLVED, That our American Medical Association support the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder. (New HOD Policy) |
| B | Res. 203 | MSS | Support Expansion of Good Samaritan LawsRESOLVED, That our AMA amend Policy D-95.977 by addition and deletion to read as follows:911 Good Samaritan Laws, D-95.977Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; ~~and~~ (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan Laws. (Modify Current HOD Policy) |
| B | Res. 204 | New York | AMA Position on Payment Provisions in Health Insurance PoliciesRESOLVED, That our American Medical Association seek legislation to ban anti-assignment provisions in health insurance plans (Directive to Take Action); and be it furtherRESOLVED, That our AMA support legislation requiring health insurers to issue payment directly to the physician when the patient or patient representative signs an agreement which permits payment directly to the physician. (Directive to Take Action) |
| B | Res. 205 | Virginia | Co-Pay AccumulatorsRESOLVED, That our American Medical Association develop model state legislation based on the recent law enacted in Virginia regarding Co-Pay Accumulators. (Directive to Take Action) |
| B | Res. 206 | IMG | Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG PhysiciansRESOLVED, That our American Medical Association support efforts to retain and incentivize international medical graduates serving in federally designated health professional shortage areas after the current allocated period. (Directive to Take Action). |
| B | Res. 207 | MSS | Pharmaceutical Advertising in Electronic Health Record SystemsRESOLVED, That our American Medical Association encourage the Centers for Medicare and Medicaid Services to study the effects of direct-to-physician advertising at the point of care, including advertising in Electronic Health Record Systems (EHRs), on physician prescribing, patient safety, health care costs, and EHR access for small practices (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the ethics of direct-to-physician advertising at the point of care, including advertising in EHRs. (Directive to Take Action) |
| B | Res. 208 | MSS | Net Neutrality and Public HealthRESOLVED, That our American Medical Association advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network (Directive to Take Action); and be it furtherRESOLVED, That our AMA collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds (Directive to Take Action); and be it further RESOLVED, That our AMA oppose internet data transmission practices that reduce market competition in the health ecosystem. (Directive to Take Action) |
| B | Res. 209  | ASTS  | Federal Government Regulation and Promoting Patient Access to Kidney TransplantationRESOLVED, That our American Medical Association engage US government regulatory and professional organ transplant organizations to advance patient and physician-directed care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it furtherRESOLVED, That our AMA actively promote regulatory efforts to assure physician and patient involvement in the design of any ESRD federal demonstration program (Directive to Take Action); and be it further RESOLVED, That our AMA actively advocate for legislative and regulatory efforts which create incentives for dialysis providers, transplant centers, organ donors, and ESRD patients to increase organ donation and improve access to kidney transplantation in the United States. (Directive to Take Action) |
| B | Res. 210  | ASTS  | Federal Government Regulation and Promoting Renal TransplantationRESOLVED, That our American Medical Association actively advocate for US organ transplant legislative and regulatory policies that would advance kidney transplantation by modifying or eliminating arbitrary transplant center outcomes measures that currently discourage sound clinical judgment by physicians and surgeons to accept and transplant kidneys suitable for many patients. (Directive to Take Action) |
| B | Res. 211  | Michigan | Effects of Net Neutrality on Public HealthRESOLVED, That our American Medical Association amend current policy H-478.980, “Increasing Access to Broadband Internet to Reduce Health Disparities,” by addition and deletion as follows:Increasing ~~Access to Broadband~~ Internet Access to Reduce Health DisparitiesOur AMA: (1) will advocate for net neutrality; and (2) will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Modify Current HOD Policy)  |
| B | Res. 212  | Michigan | Centers for Medicare and Medicaid Services Open Payments ProgramRESOLVED, That our American Medical Association amend current policy H-140.848, “Physician Payments Sunshine Act,” by addition and deletion to read as follows:Our AMA will: (1) continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by the Centers for Medicare & Medicaid Services (CMS) and will recommend to the CMS that a physician comment section be included on the "Physician Payments Sunshine Act" public database; (2) lobby Congress to amend the Sunshine Act to limit transfer of value reporting to items with a value of greater than $100; (3) advocate that: (a) (i) any payment or transfer of value reported as part of the Physician Payments Sunshine Act should include whether the physician acknowledged receipt of said payment or transfer of value, and (ii) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value; and (b) a contested reported payment or transfer of value should be removed immediately from the Open Payments website until the reporting company validates the compensation with verifiable documentation; ~~and~~ (4) support significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the regulatory and administrative burden on physicians, protect physician rights to challenge false and misleading reports, change the dispute process so that successfully disputed charges are not included publicly on the Open Payments database, and provide a meaningful, accurate picture of the physician-industry relationship; (5) urge the Centers for Medicare and Medicaid Services to expand the definition of “covered recipients” to include pharmacists and Pharmacy Benefit Managers; and (6) continue to educate physicians about the Sunshine Act and its implications in light of publicly available data on the Centers of Medicare and Medicaid (CMS) Open Payments Program website. (Modify Current HOD Policy) |
| B | Res. 213  | Colorado | Data Completeness and the House of MedicineRESOLVED, That our American Medical Association amend section 4 of policy D-155.987, “Price Transparency,” by addition to read as follows:4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases. (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA direct its advocacy team to work with the National Academy for State Health Policy (NASHP), the All-Payer Claims Database Council (APCD Council), the National Association of Health Data Organizations (NAHDO), and other interested organizations to speed promulgation of final rule making as regards Schedule J by the Department of Labor (DOL) in matters related to the *Gobeille v. Liberty Mutual Insurance Company* decision (Directive to Take Action); and be it furtherRESOLVED, That, in supporting a rule making process by the DOL in matters related to the *Gobeille v. Liberty Mutual Insurance Company* decision, our AMA support the adoption of a standardized set of health care claims data such as the Common Data Layout, support that any DOL requirement for plans to submit health care claims data must be tied to current rule making processes (such as its proposed Schedule J), and support that the DOL implement a pilot program to collect health care claims data in cooperation with state APCDs. (Directive to Take Action) |
| B | Res. 214  | New York | AMA Should Provide a Summary of Its Advocacy Efforts on Surprise Medical BillsRESOLVED, That our American Medical Association Board of Trustees provide a detailed report of its efforts and those of allies and opponents around the issue of surprise medical bills in 2019; this discussion should include the following points comparing the AMA and partners activity vs that of its opponents (the insurance companies):1) What testimony was provided at various committee meetings?2) What letters were written to various legislators?3) What grass roots efforts were performed?4) What other groups supported the efforts5) What other groups were recruited to support the efforts?6) What media efforts were performed?7) What television ads were run?8) What radio ads were run?9) What print ads were run?10) What op-ed pieces were run, in national journals, Washington journals, and regional publications?11) What meetings occurred with various legislators?12) What meetings occurred with members of the administration?13) How much money was spent on the various efforts?14) What studies were published in insurance journals, medical journals, and other journals on this matter?15) Which senators and representatives and administration members could either side count on as solid supporters?16) What level of collaboration was there with other national, state, and specialty societies and how was this carried out? (Directive to Take Action) |
| B | Res. 215  | AAD | Board Certification of Physician AssistantsRESOLVED, That our American Medical Association amend Policy H-35.965, “Regulation of Physician Assistants,” by addition and deletion to read as follows:Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; ~~and~~ (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by independent organizations to board certify physician assistants in a manner that misleads the public to believe such certification is equivalent to medical specialty board certification. (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA amend Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as followsOur AMA:1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety. 2. Opposes any action, regardless of intent, by independent organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety. 3. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination. (Modify Current HOD Policy)  |
| B | Res. 216  | AAPHP | Legislation to Facilitate Corrections-to-Community Healthcare Continuity via MedicaidRESOLVED That our American Medical Association amend item #6 of HOD Policy H-430.986, “Health Care While Incarcerated,” by addition of the word "Congress” to read as follows:6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism. (Modify Current HOD Policy)  |
| B | Res. 217  | WPS | Promoting Salary Transparency Among Veterans Health Administration Employed PhysiciansRESOLVED, That our American Medical Association encourage physician salary transparency within the Veterans Health Administration. (Directive to Take Action) |
| B | Res. 218  | ACR  | Private Payers and Office Visit PoliciesRESOLVED, That our American Medical Association with all haste directly engage and advocate with commercial insurance companies that discontinue payment for consultation codes or that are proposing to or considering eliminating payment for such codes, requesting that the companies reverse or delay such policy changes while the Centers for Medicare and Medicaid Services (CMS) updates its approach to valuation of office visits (Directive to Take Action); and be it furtherRESOLVED, That if in the CY 2020 Medicare physician fee schedule final rule CMS finalizes its proposal to increase payments for evaluation and management services, then our American Medical Association will advocate publicly and with all private payers that those private payers mirror and follow CMS’ lead in more appropriately valuing office visits, by increasing payments for evaluation and management services in their reimbursement schedules. (Directive to Take Action) |
| B | Res. 219  | ASCO  | QPP and the Immediate Availability of Results in CEHRTsRESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services to create guardrails around the “immediate” availability of laboratory, pathology, and radiology results, factoring in an allowance for physician judgement and discretion regarding the timing of release of certain results (Directive to Take Action); and be it furtherRESOLVED, That our AMA encourage vendors to implement prompts that give physicians the ability to either approve notes to just the chart or approve and publish them in both the chart and patient portal. (Directive to Take Action) |
| B | Res. 220 | MSS | Oppose Mandatory DNA Collection of MigrantsRESOLVED, That our American Medical Association oppose the collection and storage of the DNA of refugees, asylum seekers, and undocumented immigrants for nonviolent immigration-related crimes without non-coercive informed consent. (New HOD Policy) |
| B | Res. 221 | RFS | Safe Supervision of Complex Radiation Oncology Therapeutic ProceduresRESOLVED, That our American Medical Association advocate that radiation therapy services should be exempted from the Hospital Outpatient Prospective Payment System (HOPPS) rule requiring only general supervision of hospital therapeutic services (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate that direct supervision of radiation therapy services by a physician trained in radiation oncology should be required by the Centers for Medicare and Medicaid Services. (Directive to Take Action) |
| C | CME 02  | n/a | Healthcare Finance in the Medical School CurriculumThat our American Medical Association (AMA) amend Policy H-295.924, “Future Directions for Socioeconomic Education,” by addition and deletion to read as follows:“The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented ~~in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings,~~ at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage ~~representatives to~~ the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which ‘socioeconomic’ subjects are covered in the medical curriculum.” (Modify Current HOD Policy) |
| C | CME 03  | n/a | Standardization of Medical Licensing Time Limits Across States1. That our American Medical Association (AMA) urge the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams to allow sufficient time for individuals who are pursuing combined degrees (e.g, MD/PhD). (New HOD Policy)2. That our AMA urge that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances. (New HOD Policy) 3. That our AMA encourage uniformity in the time limit for completing the licensing examination sequence across states, allowing for improved inter-state mobility for physicians. (New HOD Policy) |
| C | CME 04  | n/a | Board Certification Changes Impact Access to Addiction Medicine Specialists1. That our American Medical Association (AMA) recognize the American Board of Preventive Medicine (ABPM) for developing and providing pathways for all qualified physicians to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine, in order to improve access to care for patients with substance use disorder. (Directive to Take Action)2. That our AMA rescind Policy H-300.962 (3) “Recognition of Those Who Practice Addiction Medicine,” since the ABPM certification examination in addiction medicine is now offered. (Rescind HOD Policy) |
| C | CME 06 | n/a | Veterans Health Administration Funding of Graduate Medical Education1. That our AMA support postgraduate medical education service obligations through any program where the expectation for service is explicitly delineated in the contract with the trainee. (New HOD Policy)2. That our American Medical Association (AMA) oppose the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training. (New HOD Policy) |
| C | Res. 301 | MSS | Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical SchoolsRESOLVED, That our American Medical Association amend Policy H-295.866 by addition and deletion to read as follows:Supporting Two-Interval Grading Systems for Medical Education, H-295.866Our AMA will work with stakeholders to encourage the establishment of ~~acknowledges the benefits of~~ a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum. (Modify Current HOD Policy) |
| C | Res. 302 | MSS | Strengthening Standards for LGBTQ Medical EducationRESOLVED, That our AMA amend policy H-295.878, “Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education,” by addition and deletion to read as follows:Eliminating Health Disparities – Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues, H-295.878Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include Lesbian, Gay, Bisexual, Transgender and Queer health issues in the basic science, clinical care, and cultural competency ~~curriculum~~ curricula for both undergraduate and graduate medical education; and (4) encourages the Liaison Committee on Medical Education (LCME), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to periodically reassess the current status of curricula for medical student and residency education addressing the needs of ~~pediatric and adolescent~~ Lesbian, Gay, Bisexual, Transgender and Queer patients. (Modify Current HOD Policy) |
| C | Res. 303 | MSS | Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away RotationsRESOLVED, That our American Medical Association work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting. (Directive to Take Action) |
| C | Res. 304 | Indiana | Issues with the Match, the National Residency Matching Program (NRMP)RESOLVED, That our American Medical Association redouble its efforts to promote an increase in residency program positions in the U.S. (Directive to Take Action); and be it furtherRESOLVED, That our AMA assign an appropriate AMA committee or committees to:- Study the issue of why residency positions have not kept pace with the changing physician supply and investigate what novel residency programs have been successful across the country in expanding positions both traditionally and nontraditionally.- Seek to determine what causes a failure to match and better understand what strategies are most effective in increasing the chances of a successful match, especially after a prior failure. The committee(s) would rely upon the BNRMP (Board of the National Residency Matching Program) to provide some of this information through surveys, questionnaires and other means. Valid data would be valuable to medical students who seek to improve their chances of success in The Match.- Report back to the AMA HOD with findings and recommendations (Directive to Take Action); and be it furtherRESOLVED, Because SOAP (Supplemental Offer and Acceptance Program) failed to adequately serve some physicians seeking to match this year, that our AMA support the option to allow individuals participating in one future Match at no cost (Directive to Take Action); and be it furtherRESOLVED, That in order to understand the cost of The Match and identify possible savings, our AMA encourage the Board of the National Residency Matching Program to:1. Conduct an independent and fully transparent audit of SOAP (Supplemental Offer and Acceptance Program) to identify opportunities for savings, with the goal of lowering the financial burden on medical students and new physicians2. Actively promote success for those participating in The Match by better explaining and identifying those issues that interfere with the successful match and to offer strategies to mitigate those issues. This information can be disseminated through the program website and through services such as its “Help” and “Q&A” links, and also through the AMA. (Directive to Take Action) |
| C | Res. 305 | YPS | Ensuring Access to Safe and Quality Care for our Veterans RESOLVED, That our American Medical Association amend AMA Policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:Ensuring Access to Safe and Quality Care for our Veterans H-510.9861. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans. 4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.5. Our AMA supports access to similar clinical educational resources for all health care professionals involved in the care of veterans as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed. (Modify HOD Policy) |
| C | Res. 306 | Indiana | Financial Burden of USMLE Step 2 CS on Medical StudentsRESOLVED, That our American Medical Association work with the Federation of State Medical Boards/United States Medical Licensing Examination (USMLE) to reduce the cost of the USMLE Step 2 CS exam and allow medical students to take this exam locally to defray unnecessary expenses. (Directive to Take Action)  |
| C | Res. 307 | IMG | Implementation of Financial Education Curriculum for Medical Students and Physicians in TrainingRESOLVED, That our American Medical Association work with relevant stakeholders to study the development of a curriculum during medical school and residency/fellowship training to educate them about the financial and business aspect of medicine. (Directive to Take Action) |
| C | Res. 308 | New England | Study Expediting Entry of Qualified IMG Physicians to US Medical PracticeRESOLVED, That our American Medical Association study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA. (Directive to Take Action) |
| C | Res. 309  | Georgia  | Follow-up on Abnormal Medical Test FindingsRESOLVED, That our American Medical Association advocate for the adoption of evidence-based guidelines on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes. (Directive to Take Action) |
| C | Res. 310 | RFS | Protection of Resident and Fellow Training in the Case of Hospital or Training Program ClosureRESOLVED, That our American Medical Association study and provide recommendations on how the process of assisting orphaned residents and fellows could be improved in the case of training hospital or training program closure, including: 1) The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and2) How the Centers for Medicare and Medicaid Services (CMS) and other additional or supplemental GME funding is re-distributed, including but not limited to: a. The direct or indirect classification of residents and fellows as financial assets and the implications thereof; b. The transfer of training positions between institutions and the subsequent impact on resident and fellow funding lines in the event of closure; c. The transfer of full versus partial funding for new training positions; andd. The transfer of funding for orphaned residents and fellows who switch specialties (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations which protect residents and fellows impacted by program or hospital closure which may include recommendations for: 1) Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions which minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed; 2) Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution; 3) Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and4) Protections against the discrimination of orphaned residents and fellows consistent with H-295.969 (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services and other relevant stakeholders to identify a process by which orphaned residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services, and other relevant stakeholders to: 1) Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions; and2) Create a centralized, regulated process for orphaned residents and fellows to obtain new training positions. (Directive to Take Action) |
| F | BOT 06 | n/a | Physician Health Policy Opportunity1. That our American Medical Association encourage and support efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy. (New HOD Policy)2. That our AMA significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy fellowship opportunities and help them to apply for and participate in them. (Directive to Take Action)3. That our AMA engage with alumni of health policy fellowship programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians. (Directive to Take Action)4. That our AMA include health policy content in its educational resources for members. (Directive to Take Action)5. That our AMA work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service. (Directive to Take Action) |
| F | BOT 08 | n/a | Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership That our American Medical Association continue to explore environmentally sustainable practices for *JAMA* distribution. |
| F | CLRPD 01  | n/a | Academic Physicians Section Five-Year ReviewThe Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Academic Physicians Section through 2024 with the next review no later than the 2024 Interim Meeting. (Directive to Take Action) |
| F | Comp Report | n/a | 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 be filed:1. That there be no change to the current Definitions effective July 1, 2018 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for Representation and Telephonic Per Diem except for the Governance Honorarium and Per Diem amounts as recommended in 2, 3 and 4 below.• Definition of Governance Honorarium effective July 1, 2017:The purpose of this payment is to compensate Officers, excluding Board Chair, Chair-Elect and Presidents, for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board committee, subcommittee and task force meetings, Board orientation, Board development and media training, and Board conference calls, and any associated review or preparatory work, and all travel days related to all such meetings. The Governance Honorarium also covers Internal Representation, such as section and council liaison meetings (and associated travel) or calls, up to eleven (11) Internal Representation days.• Definition of Per Diem for Representation effective July 1, 2017:The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel for Officers, excluding Board Chair, Chair-Elect and Presidents. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc., or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays.• Definition of Telephonic Per Diem for Representation effective July 1, 2017:Officers, excluding the Board Chair, Chair-Elect and Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board.2. That the Governance Honorarium for all Board members excluding, Board Chair, Board Chair-elect, President, President-elect, and Immediate Past President be increased effective July 1, 2020 to $67,000. (Directive to Take Action)3. That the Per Diem for Chair-assigned representation for all Board members excluding the Board Chair, Chair-Elect and Presidents and related travel be increased effective July 1, 2020 to $1,400 per day. (Directive to Take Action)4. That the Per Diem for Chair-assigned Telephonic Per Diem for Representation be increased effective July 1, 2020 to $700 as defined. (Directive to Take Action) |
| F | Res. 601\*\* | MSS | Amending AMA Policy G-630.140, “Lodging, Meeting Venues, and Social Functions”RESOLVED, That our American Medical Association amend Policy G-630.140, “Lodging, Meeting Venues, and Social Functions,” be amended by addition to read as follows:Lodging, Meeting Venues, and Social Functions, G-630.1401. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.4. It is the policy of our AMA not to hold national meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping. (Reaffirm HOD Policy)  |
| F | Res. 602 | YPS | Preserving Childcare at AMA MeetingsRESOLVED, That our American Medical Association continue to arrange on-site supervised childcare at AMA Annual and Interim meetings (New HOD Policy); and be it furtherRESOLVED, That our AMA offer on-site supervised childcare at no cost to AMA members and staff for Annual and Interim meetings. (New HOD Policy) |
| J | CMS 01  | n/a | Established Patient Relationships and Telemedicine1. That our American Medical Association (AMA) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services. (Directive to Take Action)
2. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-480.969, which maintains that state medical boards should require a full and unrestricted license in that state for the practice of telemedicine, with no differentiation by specialty, unless there are other appropriate state-based licensing methods, and with exemptions for emergent or urgent circumstances and “curbside consultations.” (Reaffirm HOD Policy)
 |
| J | CMS 02  | n/a | Addressing Financial Incentives to Shop for Lower-Cost Health Care1. That our American Medical Association (AMA) support the following continuity of care principles for any financial incentive program (FIP):1. Collaborate with the physician community in the development and implementation of patient incentives.
2. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
3. Provide treating physicians with access to patients’ FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
4. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
5. Provide referring and/or primary care physicians with the full record of the service encounter.
6. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
7. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans. (New HOD Policy)

2. That our AMA support the following quality and cost principles for any FIP:1. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
2. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
3. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores.
4. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician’s quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
5. Provide a process through which patients and physicians can publicly report unsatisfactory care experiences with referred lower-cost physicians or facilities.
6. Provide meaningful transparency of prices and vendors.
7. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
8. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs. (New HOD Policy)

3. That our AMA support requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services. (New HOD Policy)4. That our AMA oppose FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice. (New HOD Policy)5. That our AMA encourage state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices. (New HOD Policy)6. That our AMA encourage objective studies of the impact of FIPs that include data collection on dimensions such as:a) Patient outcomes/the quality of care provided with shopped services;b) Patient utilization of shopped services;c) Patient satisfaction with care for shopped services;d) Patient choice of health care provider;e) Impact on physician administrative burden; andf) Overall/systemic impact on health care costs and care fragmentation. (New HOD Policy) |
| J | CMS 03  | n/a | Improving Risk Adjustment in Alternative Payment Models1. That our American Medical Association (AMA) reaffirm Policy H-385.908 stating that the AMA will work with the Centers for Medicare & Medicaid Services and interested organizations to design systems that identify 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 disease stage and socio-demographic factors; account for differences in patient needs, such as functional limitations, changes in medical conditions, and ability to access health care services; and explore an approach in which the physician managing a patient’s care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy D-478.995 advocating for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records so that capturing patient characteristics and risk adjustment measures do not add to physician and practice administrative burden. (Reaffirm HOD Policy)
3. That our AMA support risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications. (New HOD Policy)
4. That our AMA support risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer’s cost. (New HOD Policy)
5. That our AMA support risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer’s cost. (New HOD Policy)
6. That our AMA support risk adjustment systems that use fair and accurate payments for external price changes beyond the physician’s control. (New HOD Policy)
7. That our AMA support accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence. (New HOD Policy)
 |
| J | CMS 04  | n/a | Mechanisms to Address High and Escalating Pharmaceutical Prices1. That our American Medical Association (AMA) advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
	1. The arbitration process should be overseen by objective, independent entities;
	2. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
	3. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
	4. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
	5. The arbitration process should include the submission of a value-based price benchmark for the drug in question to inform the arbitrator’s decision;
	6. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer/government entity;
	7. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases; and
	8. The arbitration process should include a mechanism for either party to appeal the arbitrator’s decision. (New HOD Policy)
2. That our AMA advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
	1. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
	2. Any international drug price index or average should not be used to determine or set a drug’s price, or determine whether a drug’s price is excessive, in isolation;
	3. The use of any international drug price index or average should preserve patient access to necessary medications; and
	4. The use of any international drug price index or average should limit burdens on physician practices. (New HOD Policy)
3. That our AMA support the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (New HOD Policy)
4. That our AMA reaffirm Policy H-110.983, which advocates that any revised Medicare Part B Competitive Acquisition Program meet certain outlined standards to improve the value of the program by lowering the cost of drugs without undermining quality of care. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-110.986, which outlines principles for value-based pricing programs, initiatives and mechanisms for pharmaceuticals, and supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy H-460.909, which outlines principles for creating a centralized comparative effectiveness research entity. (Reaffirm HOD Policy)
7. That our AMA reaffirm Policy D-330.954, which states that our AMA will work toward eliminating Medicare prohibition on drug price negotiation. (Reaffirm HOD Policy)
 |
| J | Res. 801 | MSS | Reimbursement for Post-Exposure Protocol for Needlestick InjuriesRESOLVED, That our American Medical Association encourage medical schools to ensure medical students can be reimbursed for the costs associated with post-exposure protocol for blood or body substance exposure sustained during clinical rotations either by their insurance provider or the state’s workers’ compensation fund, where applicable (Directive to Take Action); and be it further RESOLVED, That our AMA encourage state societies to work with their respective workers’ compensation fund to include medical students as recipients of medical benefits in the event of blood or body substance exposure during clinical rotations. (Directive to Take Action) |
| J | Res. 802 | MSS | Ensuring Fair Pricing of Drugs Developed with the United States GovernmentRESOLVED, That our American Medical Association amend Policy H-110.987 by addition to read as follows:Pharmaceutical Costs, H-110.9871. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.7. Our AMA supports legislation to shorten the exclusivity period for biologics.8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.14. Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as in individual solution or in conjunction with other approaches. (Modify Current HOD Policy) |
| J | Res. 803 | MSS | Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented PeopleRESOLVED, That our American Medical Association support expanded access to scheduled dialysis for undocumented persons with end-stage renal disease. (New HOD Policy) |
| J | Res. 804 | Indiana | Protecting Seniors from Medicare Advantage PlansRESOLVED, That our American Medical Association encourage AARP, insurance companies and other vested parties to develop simplified tools and guidelines for comparing and contrasting Medicare Advantage plans. (New HOD Policy) |
| J | Res. 805 | IMG | Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing StandardRESOLVED, That our American Medical Association advocate for legislation to create an International Pricing Index that would track global medication prices for all prescription medications and keep U.S. medication costs aligned with prices paid in other countries to help control costs and reduce unreasonable patient financial barriers to treatment (Directive to Take Action); and be it RESOLVED, That our AMA advocate for legislation that would ensure that patients are charged fairly for prescription medications based on the International Pricing Index and that additional costs will not be arbitrarily assigned or passed onto patients. (Directive to Take Action) |
| J | Res. 806 | MSS | Support for Housing Modification PoliciesRESOLVED, That our American Medical Association support legislation for health insurance coverage of housing modification benefits for: (a) the elderly; (b) other populations that require these modifications in order to mitigate preventable health conditions, including but not limited to the disabled or soon to be disabled; and (c) other persons with physical and/or mental disabilities. (New HOD Policy) |
| J | Res. 807 | New England | Addressing the Need for Low Vision Aid DevicesRESOLVED, That our American Medical Association support legislative and regulatory actions promoting insurance coverage and adequate funding for low vision aids for patients with visual disabilities. (Directive to Take Action) |
| J | Res. 808  | AAPM&R  | Protecting Patient Access to Seat Elevation and Standing Features in Power WheelchairsRESOLVED, That our American Medical Association request that the Centers for Medicare and Medicaid Services (CMS) render a benefit category determination (BCD) that establishes that the seat elevation and standing features of power wheelchairs are primarily medical in nature and qualify under the definition of durable medical equipment (DME) when used in a power wheelchair (Directive to Take Action); and be it furtherRESOLVED, That our AMA urge CMS to require the DME Medicare Administrative Contractors (MACs) to determine an appropriate coverage policy for Medicare beneficiaries in need of the seat elevation and standing features in their power wheelchairs on an individual basis according to the National Coverage Determination (NCD) for mobility assistance equipment (MAE), activate the existing Healthcare Common Procedure Coding System (**HCPCS**) codes for seat elevation and standing feature in power wheelchairs, and determine appropriate reimbursement levels for these codes in order to facilitate access to these important benefits for Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it furtherRESOLVED, That if CMS is not able or willing to provide access to seat elevation and standing feature through its administrative authority, our AMA advocate before Congress to support legislation that will clarify the DME benefit to include coverage, coding and reasonable reimbursement of standing feature and seat elevation in power wheelchairs for appropriate Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further RESOLVED, That our AMA encourage all health insurance carriers to cover standing feature and seat elevation in power wheelchairs for appropriate beneficiaries with mobility impairments. (Directive to Take Action) |
| J | Res. 809  | Utah  | AMA Principles of Medicaid ReformRESOLVED, That our American Medical Association support the following principles of Medicaid reform:1. Provide appropriate access to care that is the most cost effective and efficient to our citizens.2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible.3. Create the best coverage at the lowest possible cost.4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services.5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care.6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care.7. Assure appropriate payment and positive incentives to encourage but not require clinician participation in Medicaid for both face-to-face and non-face-to-face encounters, under appropriate establishment of clinician-patient relationship.8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours.9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health.10. Eliminate current disincentives (e.g., Medicaid spend-down in order to qualify) to patients improving their lives while on Medicaid, to increase successful transition into the private insurance market.11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid.12. Develop a physician directed clinician oversight board at the state level to insure the proper access, quality and cost of care under the Medicaid program throughout all geographically diverse areas of the states.13. Allow clinicians to see patients for more than one procedure in a visit so that patients do not have to return for another service at an extra cost to the Medicaid program and extra time and effort to the Medicaid patient (e.g., if patient comes because they are sick, allow them to have a diabetes check-up at the same time).14. Strategically plan to reduce administrative costs and burdens to clinicians, and of the Medicaid program itself, by reducing at least, but not limited to, burdensome documentation requirements, administrative obstacles, and regulatory impediments. (New HOD Policy) and be it furtherRESOLVED, That our AMA pursue action to improve the federal requirements for Medicaid programs based on the AMA’s principles of Medicaid reform (Directive to Take Action) |
| J | Res. 810  | Utah | Hospital Medical Staff PolicyRESOLVED, That our American Medical Association support and advocate that hospital medical staff leadership should be fully licensed physicians and that if others are included, they should be non-voting or advisory to the hospital medical staff members (Directive to Take Action); and be it furtherRESOLVED, That our AMA support and advocate that the decisions made by hospital medical staffs focus on quality patient care, medical staff standards and the operation of the hospital, and that those decisions not engage the medical staff in external political matters (e.g., advanced practice clinician scope of practice expansion, etc.). (Directive to Take Action); and be it furtherRESOLVED, That AMA Policy H-225.993, “Medical Staff Policy Determination,” be rescinded. (Rescind HOD Policy) |
| J | Res. 811  | Michigan | Require Payers to Share Prior Authorization Cost BurdenRESOLVED, That our American Medical Association reaffirm policies H-320.939, “Prior Authorization and Utilization Management Reform,” and H-385.951, “Remuneration for Physician Services.” (Reaffirm HOD Policy) |
| J | Res. 812  | CAP | Autopsy Standards as Condition of ParticipationRESOLVED, That our American Medical Association call upon the Centers for Medicare and Medicaid Services to reinstate the Autopsy Standard as a Medicare Condition of Participation. (Directive to Take Action)  |
| J | Res. 813  | ACR  | Public Reporting of PBM RebatesRESOLVED, That our American Medical Association advocate for Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation. (Directive to Take Action) |
| J | Res. 814  | ASCO  | PBM Value-Based Framework for Formulary DesignRESOLVED, That our American Medical Association emphasize the importance of physicians’ choice of the most appropriate pharmaceutical treatment for their patients in its advocacy; (Directive to Take Action) and be it furtherRESOLVED, That our AMA advocate for pharmacy benefit managers (PBMs) and health plans to use a value-based decision-making framework that is transparent and includes applicable specialty clinical oversight when determining which specialty drugs to give preference on their formularies. (Directive to Take Action) |
| J | Res. 815  | ASCO  | Step TherapyRESOLVED, That our American Medical Association extend its advocacy for the patient protections against step therapy protocols outlined in D-320.981, “Medicare Advantage Step Therapy,” to all health plans (Directive to Take Action); and be it furtherRESOLVED, That our AMA actively support state and federal legislation that would allow timely clinician-initiated exceptions to, and place reasonable limits on, step therapy protocols imposed by health care plans. (Directive to Take Action)  |
| J | Res. 816  | Georgia  | Definition of New PatientRESOLVED, That our American Medical Association advocate for the definition of a “new patient” to represent the multitude of factors and time needed to appropriately evaluate a patient’s health condition and in accordance with relevant payer guidelines. (Directive to Take Action) |
| J | Res. 817  | Georgia  | Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage PlansRESOLVED, That our American Medical Association advocate for transparent patient educational resources on their personal costs for their medications under Medicare Part D and Medicare Advantage plans--both printed and online video--which health care systems could provide to patients and which consumers could access directly (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for increased resources for federal and state programs like GeorgiaCares and educate physicians, hospitals, and patients about the availability of these programs. (Directive to Take Action) |
| J | Res. 818  | Maryland  | Health Insurers - Collection of Co-Pays and DeductiblesRESOLVED, That our American Medical Association study whether deductibles and co-pays should be collected by insurance companies rather than by practitioners. (Directive to Take Action) |
| J | Res. 819 | OMSS | Hospital Website Voluntary Physician InclusionRESOLVED, That our American Medical Association advocate for regulation and/or legislation requiring that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites (Directive to Take Action); and be it further RESOLVED, That our AMA study a requirement that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites with a report back at the 2020 Annual Meeting. (Directive to Take Action) |
| J | Res. 820 | RFS | E-Cigarette and Vaping Associated IllnessRESOLVED, That our American Medical Association advocate for diagnostic coding systems including ICD codes to have a mechanism to release emergency codes for emergent diseases (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for creation and release of ICD codes to include appropriate diagnosis codes for both the use of and toxicity related to e-cigarettes and vaping, including pulmonary toxicity. (Directive to Take Action) |
| K | CSAPH 01  | n/a | Mandatory Reporting of Diseases and ConditionsPublic Health SurveillanceThat our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal funding to modernize our nation’s public health data systems to improve the quality and timeliness of data; (5) supports electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting. (New HOD Policy) |
| K | CSAPH 02  | n/a | Real-World Data and Real-World Evidence in Medical Product Decision MakingThe Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:1. Our AMA supports the generation and use of real-world data (RWD) and real-world evidence (RWE) fit for regulatory purpose to: (a) evaluate effectiveness and safety of medical products, while assuring patient privacy and confidentiality; (b) improve regulatory decision-making; (c) decrease medical product costs; (d) increase research efficiency; (e) advance innovative and new models of drug development; and (f) improve clinical care and patient outcomes. (New HOD Policy)
2. Our AMA supports the aim of the U.S. Food and Drug Administration (FDA) to expand and clarify the use RWD and RWE in regulatory decision-making including in:
	1. understanding the potential of RWE to meet the established standards for adequate and well-controlled clinical investigations;
	2. pursuing the integration of RWE into medical product development and regulatory review; and
	3. utilizing RWE to support new indications for approved medical products, and its ability to satisfy post-approval study requirements. (New HOD Policy)
3. Our AMA supports that there be adequate funding of data infrastructure to allow for transparent data management capabilities, improved access to data by clinicians, especially physicians, as well as researchers and other stakeholders, and improved reliability and relevance of data. (New HOD Policy)
4. Our AMA supports cooperation and collaboration of stakeholders to facilitate the collection and use of RWD and RWE that is deemed fit for regulatory purpose. (New HOD Policy)
5. Our AMA will evaluate and develop a response to the educational needs of physicians seeking to understand the use of fit for purpose RWD and RWE in clinical practice. (New HOD Policy)
6. That Policy H-100.992, “FDA,” be amended by addition to read as follows:

H-100.992, “FDA”1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. (Modify Current HOD Policy)
4. That Policy D-100.982, “Enhanced Physician Access to Food and Drug Administration Data,” urging the FDA to apply new tools to gather data after drugs are approved for marketing, including a broader use of targeted post-approval studies, institution of active and sentinel event surveillance, and data mining of available drug utilization databases, be reaffirmed. (Reaffirm Current HOD Policy)
5. That Policy H-110.986, “Incorporating Value into Pharmaceutical Pricing” supporting value-based pricing of pharmaceuticals that is evidence-based and the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes, be reaffirmed. (Reaffirm Current HOD Policy)
6. That Policy H-406.987, “Medical Information and Its Uses,” identifying three components of a data transparency framework, be reaffirmed. (Reaffirm Current HOD Policy)
7. That Policy H-410.948, “Clinical Pathways,” supporting the development of transparent, collaboratively constructed clinical pathways that are implemented in ways that promote administrative efficiencies for both providers and payers; promote access to evidence-based care for patients; recognize medical variability among patients and individual patient autonomy; promote access to clinical trials; and are continuously updated to reflect the rapid development of new scientific knowledge, be reaffirmed. (Reaffirm Current HOD Policy)
8. That Policy H-450.933, “Clinical Data Registries,” encouraging multi-stakeholder efforts to develop and fund clinical data registries to facilitate quality improvements and research that results in better health care, improved population health, and lower costs be reaffirmed. (Reaffirm Current HOD Policy)
9. That Policy D-460.970, “Access to Clinical Trial Data,” urging the FDA to investigate and develop means by which scientific investigators can access original source safety data from industry-sponsored trials upon request; be reaffirmed. (Reaffirm Current HOD Policy)
 |
| K | CSAPH 03  | n/a | Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in HospitalsThe Council recommends that the following recommendation be adopted in lieu of Resolution 414-A-19, and the remainder of the report be filed.The AMA encourages hospitals and health systems to: (1) engage stakeholders, including, but not limited to physicians, nurses, pharmacists, legal counsel, experts in controlled substance diversion prevention, as well as relevant state and federal agencies in developing policies for addressing patient use of non-FDA approved cannabis or cannabis-derived products for use within their facilities and (2) communicate their policy on patient use of non-FDA approved cannabis or cannabis-derived products within their facilities, to ensure clinicians are prepared to treat patients in accordance with policy. (New HOD Policy) |
| K | Res. 901 | MSS | Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking WaterRESOLVED, That our American Medical Association support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances. (New HOD Policy) |
| K | Res. 902 | MSS | Amending H-490.913, “Smoke-Free Environments and Workplaces,” and H‑490.907, “Tobacco Smoke Exposure of Children in Multi-Unit Housing,” to Include E-CigarettesRESOLVED, That our American Medical Association amend policy H-490.913, “Smoke-Free Environments and Workplaces,” by addition and deletion to read as follows: Smoke-Free and Vape-Free Environments and Workplaces, H-490.913On the issue of the health effects of environmental tobacco smoke (ETS), ~~and~~ passive smoke, and vape exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, cigar, and e-cigarette smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA amend Policy H-490.907, “Tobacco Smoke Exposure of Children in Multi-Unit Housing,” to include e-cigarettes and vaping by addition to read as follows: Tobacco Smoke and Vaping Exposure of Children in Multi-Unit Housing, H‑490.907 Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing. (Modify Current HOD Policy) |
| K | Res. 903 | MSS | Encouraging the Development of Multi-Language, Culturally Informed Mobile Health ApplicationsRESOLVED, That AMA amend policy D-480.972 by addition to read as follows:Guidelines for Mobile Medical Applications and Devices, D-480.9721. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based.4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed content catered to underserved and low-income populations. (Modify Current HOD Policy) |
| K | Res. 904 | MSS | Amendment to AMA Policy H-150.949, “Healthy Food Options in Hospitals”RESOLVED, That our AMA encourage the availability of healthy, plant-based options at medical care facilities by amending AMA Policy H-150.949, “Healthy Food Options in Hospitals,” by addition and deletion to read as follows:Healthy Food Options in ~~Hospitals~~ Medical Care Facilities, H-150.9491. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on ~~hospital~~ the premises of Medical Care Facilities.2. Our AMA hereby calls on ~~US hospitals~~ all Medical Care Facilities and Correctional Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.3. Our AMA hereby calls for ~~hospital~~ Medical Care Facility cafeterias and inpatient meal menus to publish nutrition information. (Modify Current HOD Policy) |
| K | Res. 905 | MSS | Sunscreen Dispensers in Public Spaces as a Public Health MeasureRESOLVED, That our American Medical Association support free public sunscreen programs in public spaces where the population would have a high risk of sun exposure. (New HOD Policy) |
| K | Res. 906 | MSS | Ensuring the Best In-School Care for Children with Sickle Cell DiseaseRESOLVED, That our American Medical Association support the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises (New HOD Policy); and be it further RESOLVED, That our AMA support the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections. (New HOD Policy) |
| K | Res. 907 | MSS | Increasing Access to Gang-Related Laser Tattoo Removal in Prison and Community SettingsRESOLVED, That our American Medical Association support increased access to gang-related tattoo removal in prison and community settings. (New HOD Policy) |
| K | Res. 908 | MSS | Request for Benzodiazepine-Specific Prescribing Guidelines for PhysiciansRESOLVED, That our American Medical Association support the creation of national benzodiazepine-specific prescribing guidelines for physicians. (New HOD Policy) |
| K | Res. 909 | RFS | Decreasing the Use of Oximetry Monitors for the Prevention of Sudden Infant Death SyndromeRESOLVED, That our American Medical Association oppose the sale and use of oximetry monitors to prevent sudden infant death syndrome. (New HOD Policy) |
| K | Res. 910 | MAS | Ban on Electronic Nicotine Delivery System (ENDS) ProductsRESOLVED, That our American Medical Association advocate for regulatory, and/or legislative, and/or legal action at the federal and/or state levels to ban all Electronic Nicotine Delivery Systems (ENDS) products. (Directive to Take Action) |
| K | Res. 911 | YPS | Basic Courses in Nutrition RESOLVED, That our American Medical Association amend Policy H-150.995, “Basic Courses in Nutrition,” by addition to read as follows:Basic Courses in Nutrition H-150.9951. Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels.2. Our AMA encourages collaboration with appropriate entities to develop and promote relevant nutrition education to enhance patient care and medical trainee education and wellbeing.3. Our AMA encourages alignment with evidence-based dietary guidelines for food served in medical trainings and medical conferences. (Modify Current HOD Policy) |
| K | Res. 912 | YPS | Improved Emergency Response Planning for Infectious Disease OutbreaksRESOLVED, That our American Medical Association encourage hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery (Directive to Take Action); and be it furtherRESOLVED, That our AMA support flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas (Directive to Take Action); and be it furtherRESOLVED, That our AMA encourage health departments to develop public health messaging to provide education on unexpected infectious disease. (Directive to Take Action) |
| K | Res. 913 | YPS | Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use RESOLVED, That our American Medical Association work with interested organizations to collate existing worldwide data on the public health impacts, societal impacts, and unintended consequences of legalization and/or decriminalization of cannabis for recreational and medicinal use, with a report back at the 2020 Interim Meeting (Directive to Take Action); and be it furtherRESOLVED, That our AMA continue to encourage research on the unintended consequences of legalization and decriminalization of cannabis for recreational and medicinal use in an effort to promote public health and public safety (Directive to Take Action); and be it further RESOLVED, That our AMA encourage dissemination of information on the public health impacts of legalization and decriminalization of cannabis for recreational and medicinal use, with consideration of making links to that information available on the AMA website (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with interested organizations to lobby Congress to allow more sites to conduct research on the risks and benefits of cannabinoid products. (Directive to Take Action) |
| K | Res. 914 | Indiana | Nicotine Replacement Therapy for MinorsRESOLVED, That our American Medical Association seek immediate and thorough study of the use of all forms of nicotine delivery, as well as all nicotine addiction treatment options in populations under the age of 18 (Directive to Take Action); and be it furtherRESOLVED, That our AMA support federal regulation that encourages manufacturers of nicotine addiction treatment therapy approved for adults to examine their products’ effects in populations under age 18. (Directive to Take Action) |
| K | Res. 915 | ACC | Preventing Death and Disability Due to Particulate Matter Produced by AutomobilesRESOLVED, That our American Medical Association promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation. (New HOD Policy) |
| K | Res. 916 | ACC | Sale of Tobacco in Retail PharmaciesRESOLVED, That our American Medical Association widely publicize opposition to pharmacies selling tobacco products, especially to minors, and seek active collaboration with other healthcare professionals through their professional organizations, especially pharmacists, but including all healthcare team members, to persuade all retailers of prescription pharmaceuticals to immediately cease selling tobacco products, with a report back at the 2020 Annual Meeting. (Directive to Take Action) |
| K | Res. 917 | MSS | Supporting Research into the Therapeutic Potential of PsychedelicsRESOLVED, That our American Medical Association call for the status of psychedelics as Schedule I substances be reclassified into a lower schedule class with the goal of facilitating clinical research and developing psychedelic-based medicines (Directive to Take Action); and be it further RESOLVED, That our AMA explicitly support and promote research into the therapeutic potential of psychedelics to help make a more conducive environment for research, given the high regulatory and cultural barriers (Directive to Take Action); and be it further RESOLVED, That our AMA support and promote research to determine the benefits and adverse effects of long-term psychedelic use. (Directive to Take Action) |
| K | Res. 918 | New England | Banning Flavors, including Menthol and Mint, in Combustible and Electronic Cigarettes and Other Nicotine ProductsRESOLVED, That our American Medical Association amend Policy H-495.971, “Opposition to Addition of Flavors to Tobacco Products,” by addition as follows:Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint and wintergreen flavors; (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products; and (3) encourages the FDA to prohibit the use of all flavoring agents in tobacco products, which includes electronic nicotine delivery systems as well as combustible cigarettes, cigars and smokeless tobacco (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA amend Policy H-495.976, “Opposition to Exempting the Addition of Menthol to Cigarettes,” by addition and deletion as follows:Our AMA: (1) will continue to support a ban on the use and marketing of menthol in ~~cigarettes~~ all tobacco products as a harmful additive; and (2) encourages and will assist its members to seek state bans on the sale of menthol cigarettes, electronic nicotine delivery devices and other tobacco products. (Modify Current HOD Policy) |
| K | Res. 919  | ATS  | Raising Awareness of the Health Impact of CannabisRESOLVED, That our American Medical Association coordinate with other health organizations to develop medical resources on the known and anticipated impact of cannabis on human health and on methods for counseling and educating patients who use cannabis and cannabinoids (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for stronger public health messaging on the negative effects of cannabis and cannabinoid inhalation and ingestion (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for urgent regulatory changes necessary to fund and perform research related to cannabis and cannabinoids (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for minimum purchasing age for cannabis products of at least 21 years old (Directive to Take Action); and be it furtherRESOLVED, That our AMA continue to use the term “cannabis” in our policies when referencing cannabis plants, and “cannabis derivatives” or “cannabinoids” when referencing their natural chemical derivatives, but will include the term “marijuana” in physician and public education messaging and materials to improve health literacy (Directive to Take Action); and be it furtherRESOLVED, That our AMA amend policy H-95.924, “Cannabis Legalization for Recreational Use,” by addition and deletion to read as follows:Cannabis Legalization for Recreational Use H-95.924Our AMA: (1) ~~believes~~ warns that cannabis and cannabinoids can be a threat to health when inhaled or ingested; (2) advocates that cannabis and cannabinoids are ~~is a dangerous drug and as such is~~  a serious public health concern; (~~2~~3) ~~believes that~~ warns against the legalized use and sale of cannabis and cannabinoids for recreational ~~use should not be legalized~~ purposes, due to their negative impact on human health; (~~3~~4) ~~discourages~~ warns against cannabis and cannabinoid use for recreational purposes, especially by ~~persons vulnerable to the drug's effects and in high-risk populations such as youth,~~ children and young adults, pregnant women, and women who are breastfeeding; (~~4~~5) ~~believes~~ strongly advocates that states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate ~~the product~~ cannabis and cannabinoids effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (~~5~~6) strongly encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis and cannabinoid use; and (~~6~~7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis or cannabinoids for personal use. (Modify Current HOD Policy) |
| K | Res. 920  | AAPHP  | Maintaining Public Focus on Leading Causes of Nicotine-Related DeathRESOLVED, That in public statements on nicotine issues, and in discussions with government officials, our AMA seek every reasonable opportunity to remind the American public about: (1) the massive ongoing death toll from combustible cigarettes; (2) the large and solidly demonstrated death toll from environmental tobacco smoke; and (3) the ongoing need for every smoker to find the best possible way to achieve and maintain abstinence from combustible cigarettes. (Directive to Take Action)  |
| K | Res. 921  | Madejski | Vaping in New York State and NationallyRESOLVED, That our American Medical Association cooperate with the Medical Society of the State of New York (MSSNY) to express our gratitude to New York Governor Andrew Cuomo and Commissioner of the Department of Health Howard Zucker, MD for their prompt action to protect patients by banning the sale of flavored e cigarettes (Directive to Take Action); and be it furtherRESOLVED, That our AMA cooperate with MSSNY to express our gratitude to Governor Cuomo and Health Commissioner Zucker for their advice to consumers to avoid vaporization of medical marijuana available under the New York State medical marijuana program (Directive to Take Action); and be it furtherRESOLVED, That our AMA cooperate with MSSNY to recommend to Governor Cuomo, Commissioner Zucker, and New York State Legislators, and in conjunction with other State Medical Societies, other State Executives, Health Commissioners and Legislatures to take further action to protect consumers from exposure to vaporized products with a moratorium on dispensing of vaporized products to new certificate holders for medical marijuana until data on the long term safety of vaporized marijuana is available (Directive to Take Action); and be it further RESOLVED, That our AMA cooperate with MSSNY to recommend that state and federal representatives work to reschedule marijuana and its’ component substances to Schedule II controlled substance to reduce barriers to further study on the efficacy and harms of various marijuana products. (Directive to Take Action) |
| K | Res. 922 | Michigan | Understanding the Effects of PFAS on Human HealthRESOLVED, That our American Medical Association advocate for continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for states to minimally follow guidelines regarding levels of perfluoroalkyl and polyfluoroalkyl chemicals recommended by the Centers for Disease Control and Prevention and the Environmental Protection Agency. (Directive to Take Action) |
| K | Res. 923  | Michigan | Support Availability of Public Transit SystemsRESOLVED, That our American Medical Association amend current policy H-135.939, “Green Initiatives and the Health Care Community,” by addition and deletion as follows:Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; ~~and~~ (5) the establishment, expansion, and continued maintenance of affordable, reliable public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities (New HOD Policy); and be it furtherRESOLVED, That our AMA amend current policy H-425.993, “Health Promotion and Disease Prevention,” by addition and deletion as follows:The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (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 abuse, particularly that which leads to 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; ~~and~~ (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, reliable public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. (Modify Current HOD Policy) |
| K | Res. 924 | Michigan | Update Scheduled Medication ClassificationRESOLVED, That our American Medical Association amend current policy D-120.979, “DEA Regulations and the Ability of Physicians to Prescribe Controlled Medication Rationally, Safely, and Without Undue Threat of Prosecution,” by addition as follows:Our AMA supports ongoing constructive dialogue between the DEA and clinicians, including physicians, regarding: (1) a proper balance between the needs of patients for treatment and the needs of the government to provide oversight and regulation to minimize risks to public health and safety; and (2) potential changes to the controlled substances schedules to make it easier to differentiate opioid containing controlled substances from non-opioid controlled substances within each schedule. (Modify Current HOD Policy) |
| K | Res. 925  | California  | Suspending Sales of Vaping Products / Electronic Cigarettes Until FDA ReviewRESOLVED, That our American Medical Association support regulations that would prohibit the sale of any e-cigarette or other vaping product that has not undergone U.S. Food and Drug Administration (FDA) pre-market review until the FDA completes its review and allows the products to be sold. (New HOD Policy) |
| K | Res. 926\*\*  | WPS | School Resource Officer Qualifications and TrainingRESOLVED, That our American Medical Association encourage an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors (New HOD Policy); and be it furtherRESOLVED, That our AMA encourage mandatory reporting of de-escalation procedures by school resource officers and tracking of student demographics of those reprimanded to identify areas of implicit bias. (Directive to Take Action) |
| K | Res. 927  | Washington | Climate ChangeRESOLVED, That our American Medical Association acknowledge that:1. Climate change is a critical public health issue.2. Potential effects of climate change on human health include higher rates of respiratory and heat-related illness, increased prevalence of vector-borne and waterborne diseases, food and water insecurity, and malnutrition. Persons who are elderly, sick, or poor are especially vulnerable to these potential consequences.3. We support educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.4. We recognize the importance of physician involvement in policymaking at the state, national, and global level and support efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and recognize that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.5. We encourage physicians to adopt programs for environmental sustainability in their practices, share these concepts with their patients and their communities. and to serve as role models for promoting environmental sustainability.6. We encourage physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently.7. We support epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. (New HOD Policy) |
| K | Res. 928  | ASCO  | CBD Oil and Supplement Use in TreatmentRESOLVED, That our American Medical Association actively support and promote private and publicly funded research to support future evidence-based policymaking on Cannabidiol (CBD) products. (Directive to Take Action) |
| K | Res. 929  | AAPHP  | Regulating Marketing and Distribution of Tobacco Products and Vaping-Related ProductsRESOLVED, That our American Medical Association support strict marketing standards to prevent all nicotine-related products from being marketed to, or attractive to, children, adolescents, and young adults, including but not limited to the following measures:* Banning print advertising except in adult-only publications or media (adults are >85% of audience).
* Banning advertising and/or sponsorship at stadiums, concerts, sporting or other public events that are not primarily targeted to adults.
* Banning offers of any school or college scholarships by any company selling tobacco products.
* Banning television advertising of any tobacco products, including any vapor products.
* Banning advertising, marketing and sale of tobacco products that:
	+ Uses the terms "candy" or "candies" or variants in spelling, such as "kandy" or "kandeez," "bubble gum," "cotton candy," and "gummi bear", and "milkshake."
	+ Uses the terms "cake" or "cakes" or variants such as "cupcake."
	+ Uses packaging, trade dress or trademarks that imitate those of food or other products primarily targeted to minors such as candy, cookies, juice boxes or soft drinks.
	+ Uses packaging that contains images of food products primarily targeted to minors such as juice boxes, soft drinks, soda pop, cereal, candy, or desserts.
	+ Imitates a consumer product designed or intended primarily for minors
	+ Uses cartoons or cartoon characters.
	+ Uses images or references to superheroes.
	+ Uses any likeness to images, characters, or phrases that are known to appeal primarily to minors, such as "unicorn".
	+ Uses a video game, movie, video, or animated television show known to appeal primarily to minors.
* Banning advertising and marketing of tobacco products, including vapor products, that:
	+ Does not accurately represent the ingredients contained in the products.
	+ Uses contracted spokespeople or individuals that do not appear to be at least 25 years of age.
* Banning advertising on outdoor billboards near schools and playgrounds.
* Requiring labels to include warnings protecting youth such as "Sales to Minors Prohibited" or "Underage Sales Prohibited" and/or "Keep Out of Reach of Children".
* Requiring all advertising to be accurate and not misleading (New HOD Policy); and be it further

RESOLVED, That our AMA support the use of the most up-to-date and effective technology for verifying the age of would-be purchasers of tobacco products and vaping-related products, both online and in bricks-and-mortar retail outlets (New HOD Policy); and be it furtherRESOLVED, That our AMA oppose sales of tobacco products or vaping-related products on any third-party marketplace such as Alibaba, Amazon, eBay, et al, where the third-party marketplace does not take full responsibility for verifying age; blocking unregulated cannabis and THC products; identifying and prohibiting all counterfeit products; and forbidding packaging and other materials that allow illicit sales of any tobacco product (New HOD Policy); and be it furtherRESOLVED, That our AMA support licensing and frequent inspections of all retail outlets selling any tobacco products or vaping-related products, with loss of license for repeated violations (e.g., three violations in a three year period) (New HOD Policy); and be it furtherRESOLVED, That our AMA support limitations on the concentration, chemical form, and vehicle chemistry of all nicotine-related products, with special attention to the European product standards which seem to lead to much lower addictiveness than many of the ENDS products sold in the USA (New HOD Policy); and be it furtherRESOLVED, That our AMA support a ban on all self-service displays of tobacco products, which would require all tobacco products and vaping-related products to be behind a counter or in a locked display and accessible only to a store employee (New HOD Policy); and be it furtherRESOLVED, That our AMA support a ban on sales of all tobacco products and vaping-related products except in stores that display signage indicating that (a) "Unaccompanied Minors Are Not Allowed on Premises" or (b) "Products are Not for Sale to Minors" or (c) "Underage Sale Prohibited", and that enforce these rules consistently (New HOD Policy); and be it furtherRESOLVED, That our AMA support a ban on “straw man” sellers, which would make it illegal for any person who is not a licensed tobacco product dealer or vaping-related product dealer to sell, barter for, or exchange any tobacco product or vaping-related products (New HOD Policy); and be it furtherRESOLVED, That our AMA support legislation that would discourage “straw man” distribution by prohibiting the retail sale of quantities likely intended for more than one consumer, such as the retail sale to one customer of (a) more than two electronic-cigarette or vape devices; (b) more than five standard packages of e-liquids; (c) more than 20 packs of cigarettes; or (d) similarly determined quantities of other tobacco products and/or vaping-related products. (New HOD Policy) |
| K | Res. 930  | Georgia  | Origin of Prescription Medication Production TransparencyRESOLVED, That our American Medical Association advocate to Congress to support national legislation to make it a requirement that the identity of the manufacturer(s) and the country (countries) of origin of the components of prescription medications be included on the label of the container dispensed to a patient, including generic medications. (Directive to Take Action) |
| K | Res. 931  | Georgia  | Vaping Ban for Under 21 and Additional RegulationsRESOLVED, That our American Medical Association reaffirm policy on tobacco sales and flavoring and renew efforts to advocate to make these policies universal in all the states in the Union. (Directive to Take Action) |
| K | Res. 932  | Pennsylvania  | Source and Quality of Medications Critical to National Health and SecurityRESOLVED, That our American Medical Association support studies that identify the extent to which the United States is dependent on foreign supplied pharmaceuticals and chemical substrates (New HOD Policy); and be it furtherRESOLVED, That our AMA support legislative and regulatory initiatives that help to ensure proper domestic capacity, production and quality of pharmaceutical and chemical substrates as a matter of public well-being and national security (New HOD Policy); and be it furtherRESOLVED, That our AMA encourage the development and enforcement of standards that make the sources of pharmaceuticals and their chemical substrates used in the United States of America transparent to prescribers and the general public. (New HOD Policy) |
| K | Res. 933  | Maryland  | Supporting Research Into the Therapeutic Potential of PsychedelicsRESOLVED, That our American Medical Association work to establish a waiver process for psychedelics as Schedule 1 substances with the goal of facilitating clinical research. (Directive to Take Action) |
| K | Res. 934  | Maryland  | Gun Violence and Mental Illness Stigma in the MediaRESOLVED, That our American Medical Association amend Policy H-145.971, “Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings,” by addition to read as follows: Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage of mass shootings, including for accurate and sensitive discussion of the purported relationship between mental illness and gun violence. (Modify Current HOD Policy) |
| K | Res. 935 | OMSS | AMA Response to a National Vaping EpidemicRESOLVED, That our American Medical Association adopt an immediate AMA declaration that the vaping epidemic has escalated, leading to life-threatening illnesses and if unchecked will become an epidemic of epic proportions, labeling it now as a National Public Health Emergency Crisis (Directive to Take Action); and be it furtherRESOLVED, That our AMA, having declared vaping a Public Health Emergency Crisis, advocate for an immediate legislative ban on vaping at the national level, with a minimal duration of one year and which emulates shorter bans already in place in several states (Directive to Take Action); and be it furtherRESOLVED, That during any ban on vaping, our AMA advocate for emergency government research funding, under the direction of the Centers for Disease Control and Prevention, at a level sufficient to study and combat both the nicotine addiction and the direct pulmonary toxicity from the use of electronic nicotine delivery systems (Directive to Take Action); and be it furtherRESOLVED, That our AMA direct the Public Education Programs of the AMA to disseminate its own teaching materials (or those of sister organizations) to warn of the dangers of vaping. Such materials would be tailored for specific age group blocks, beginning with the late primary school age group (Directive to Take Action); and be it further RESOLVED, That our AMA adopt an immediate declaration and advocate for legislative action that requires the vaping industry to follow the same restrictions as the tobacco industry in direct-to-consumer advertising/marketing of their products. (Directive to Take Action) |

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

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

\*\* Resolution recommended against consideration at I-19.