

**MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY**

ROBERT WILLIAM DAVIS, JR.

Introduced by Susan R. Bailey, MD, Delegate; and Bruce A. Scott, MD, Delegate

Whereas, Robert William Davis, Jr., was the Senior Vice President for Human Resources and Corporate Services at our AMA for many years before retiring on May 17; and

Whereas, Robert William Davis, Jr., was better known to all who knew him as Bob Davis; and

Whereas, Bob worked closely with multiple members of the House of Delegates who served on the Selection Committee for the Public Member of the Board of Trustees; and

Whereas, Bob worked with the House of Delegates Committee on Compensation of the Officers for many years as well; and

Whereas, Bob's work on behalf of and for the House of Delegates extended to many areas that are largely behind the scenes, including contracting for Annual and Interim Meetings, arrangements for child care, security in the House, and the development of our code of conduct; and

Whereas, Bob made innumerable contributions to our Board of Trustees as they conducted the business of our AMA and executed the policies adopted by the House of Delegates; and

Whereas, Bob brought an appreciation of the humanity of each individual to all his work, but especially to his efforts in human resources; and

Whereas, Bob was a loyal alumnus and fan of Michigan State University and an avid golfer in his free time; and

Whereas, Bob passed away on May 30 at the age of 65; and

Whereas, Bob leaves behind his loving wife Chong Sun (nee Ahn) Davis, his cherished brother George Davis and sister Lisa Shankle as well as nieces, nephews and cousins; and

Whereas, His colleagues at our American Medical Association shall miss his quick humor, balanced perspective, and leadership; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions made by Robert William Davis, Jr., to our Association and through it to the larger profession; and be it further

RESOLVED, That our American Medical Association House of Delegates express its sympathy for the death of Robert William Davis Jr. to his family and present them with a copy of this resolution.

JOHN A. KNOTE, MD

Introduced by Indiana and the AMA Senior Physicians Section

Whereas, Dr. John A. Knote, MD, a radiologist who practiced in Lafayette and Indianapolis, Indiana, passed away on April 22, 2019; and

Whereas, Dr. Knote graduated from Purdue University with a degree in Physical Education for Men and was the third person ever to represent the university as "Purdue Pete"; and

Whereas, Dr. Knote graduated from Indiana University School of Medicine, and continued his post-graduate education through an Internship at Baptist Memorial Hospital in Memphis, and Radiology Residency at Indiana University; and

Whereas, Dr. Knot promoted improving the practice of medicine in many ways including service to the Indiana State Medical Association, culminating as ISMA President in 1983-84, and numerous positions in the American College of Radiology (from whom he received the Gold Medal), the American Roentgen Ray Society, the Radiologic Society of North America and the American College of Nuclear Medicine; and

Whereas, Dr. Knot continued his service to the medical profession through the American Medical Association (where his exploits are legendary), ultimately serving as Speaker of the House of Delegates from 2000-2003; and

Whereas, Dr. Knot continued his contributions to the AMA through the Senior Physicians Section, serving as Chair of the Senior Physicians Section Governing Council in 2009-2010; and

Whereas, Dr. Knot continued throughout his life to be a valued mentor to all who sought his counsel with honest, respectful, and often humorous advice that will be sorely missed by all who knew him; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Dr. John A. Knot's outstanding service to the profession; and be it further

RESOLVED, That a copy of this resolution be recorded in the proceedings of this House and be forwarded to his family with an expression of the House's deepest sympathy.

MARVIN HORTON RORICK, III, MD
Introduced by Ohio

Whereas, Marvin H. Rorick III, MD, an esteemed member of the Academy of Medicine of Cincinnati, Ohio State Medical Association, and American Medical Association, passed away suddenly on August 2, 2018; and

Whereas, Dr. Rorick received his MD degree in 1984 from University of Cincinnati College of Medicine, served his internship at Good Samaritan Hospital, and his residency at University of Cincinnati Medical Center; and

Whereas, Dr. Rorick was president of the Academy of Medicine of Cincinnati in 1998 and was an active member of numerous committees and boards, including Legislative Affairs, Communications, Program, Membership, Academy Council, and The Medical Foundation; and

Whereas, Dr. Rorick was actively involved for many years with the OSMA, serving as a long-time member of the First District Delegation to the OSMA House of Delegates, First District Councilor from 2004-2010, and chair of the Organized Medical Staff Section from 2014-2018; and

Whereas, Dr. Rorick was the District 1 Chair of the OSMA Political Action Committee; and

Whereas, Dr. Rorick was active in many community activities and organizations including Hospice of Cincinnati, Ohio Valley Life Center, Cincinnati Council for Epilepsy, and Greater Cincinnati Foundation, and was chosen to participate in Leadership Cincinnati Class XXI; and

Whereas, Dr. Rorick worked throughout his more than 30-year medical career to bring the best possible medical care to his patients in the Greater Cincinnati area and was well respected in the local medical community by both his colleagues and his patients; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions made by Dr. Rorick to the medical profession, as well as the Greater Cincinnati community; and, be it further

RESOLVED, That our American Medical Association House of Delegates express its sympathy for the death of Dr. Rorick to his family and present them with a copy of this resolution.

RALPH E. SCHLOSSMAN, MD
Introduced by New York

Whereas, it is with the deepest regret that we mourn the passing of our esteemed colleague and friend, Ralph E. Schlossman, MD, on January 17, 2019; and

Whereas, Dr. Schlossman was born in Brooklyn, NY; graduated from the Polytechnic Preparatory School and Syracuse University; received his medical degree in 1955 from the New York University Bellevue College of Medicine; and completed his internship at the Kings County Hospital Center in Brooklyn in 1956; and

Whereas, Dr. Schlossman served his Country in the United States Air Force from 1956 to 1958; serving as Chief Flight Surgeon of the 31st Tactical Fighter Wing and Commander of the 31st Tactical Hospital; and was one of the first physicians to fly faster than the speed of sound; and

Whereas, Dr. Schlossman was a Diplomate of the American Board of Family Medicine and held teaching positions at the State University of New York Downstate Medical Center, the New York Hospital Weill College of Medicine of Cornell University, and the Touro College of Osteopathic Medicine; and was an attending physician at State University Hospital in Brooklyn and New York Hospital Queens; and

Whereas, Dr. Schlossman joined both the Medical Society of the County of Queens (MSCQ) and the Medical Society of the State of New York (MSSNY) in December 1958; and served faithfully on numerous committees and in multiple officer positions; and

Whereas, Dr. Schlossman served as President of the Medical Society of the County of Queens in 1970-1971; served on the MSCQ Board of Trustees from 1972-1984 and subsequently as its Chair for over twenty years and was serving as Trustee Emeritus until his passing; and

Whereas, Dr. Schlossman was the recipient of the Medical Society of the County of Queens highest honor, the MSCQ Lifetime Achievement Award; and

Whereas, Dr. Schlossman served as President of the Medical Society of the State of New York in 1998-1999; and served on the MSSNY Board of Trustees from 2000-2005 and as its Chair in 2004-2005; and

Whereas, Dr. Schlossman was the recipient of the Medical Society of the State of New York highest honor, the Henry I. Feinberg Award for Leadership; and

Whereas, Dr. Schlossman was a longtime delegate from the MSCQ to the MSSNY and from the MSSNY to the American Medical Association (AMA); and

Whereas, Dr. Schlossman practiced Family Medicine in Queens for over 50 years; was a regular health news contributor to Queens Public Access Cable TV; and mentored many medical students and physicians, including two individuals who also became Presidents of the Medical Society of the State of New York; and

Whereas, Dr. Schlossman possessed a warm sense of humor and delighted in turning frowns into smiles and laughter; and

Whereas, Dr. Schlossman leaves a legacy of service and leadership to his Country and to the profession of medicine and will be dearly remembered by the numerous patients for whom he cared; and by his numerous friends and colleagues; and

Whereas, Dr. Schlossman enjoyed a long and loving marriage to his wife, Ruth, who passed away on March 9, 2019; and

Whereas, Dr. Schlossman leaves a legacy of quiet dignity, leadership, honor, integrity, and boundless love for his children, Marcie, Andrew, and Wendy; and his grandchildren; therefore, be it

RESOLVED, that this House of Delegates of the American Medical Association express its sorrow at the passing of our dear friend and colleague, Ralph E. Schlossman, MD, and that this resolution be made part of the Proceedings of the 2019 House of Delegates.

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Sunday, June 9. The following resolutions were dealt with on the reaffirmation calendar: 103, 104, 106, 108, 110, 118, 121, 128, 130, 202, 205, 209, 215, 222, 225, 230, 234, 238, 305, 306, 309, 320, 422, 506, 509, 521, 523, 701, 707, 715 and 716.

1. OPPOSING ATTORNEY PRESENCE AT AND/OR RECORDING OF INDEPENDENT MEDICAL EXAMINATIONS

Introduced by Illinois

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association amend Policy H-365.981, “Workers’ Compensation,” by addition to read as follows:

Our AMA:

- (1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development.
- (2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.
- (3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.
- (4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.
- (5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.
- (6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.
- (7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.
- (8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.
- (9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.
- (10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.
- (11) opposes the ability of courts to compel recording and videotaping of, or allow a court reporter or an opposing attorney to be present during, the independent medical examination, as a condition for the physician's medical opinions to be allowed in court.; and be it further

RESOLVED, That revised AMA Policy H-365.981, “Workers Compensation,” be included in the AMA’s *Guide to the Evaluation of Permanent Impairment*.

2. ADDRESSING EXISTENTIAL SUFFERING IN END-OF-LIFE CARE **Introduced by Minnesota**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association ask the Council on Judicial and Ethical affairs to review Ethical Opinion 5.6, “Sedation to Unconsciousness in End-of-Life Care,” to address the following two issues: appropriate treatments beyond social, psychological or spiritual support to treat existential suffering, and the recognition of a patient’s previously expressed wishes with end-of-life care.

3. CONFORMING SEX AND GENDER DESIGNATION ON GOVERNMENT IDS AND OTHER DOCUMENTS **Introduced by GLMA: Health Professionals Advancing LGBTQ Equality**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy H-65.967

RESOLVED, That our American Medical Association modify HOD Policy H-65.967, “Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients,” by addition and deletion to read as follows:

H-65.967, Conforming ~~Birth Certificate Policies to Current Medical Standards for Transgender Patients~~ Sex and Gender Designation on Government IDs and Other Documents

1. Our AMA supports ~~policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care~~ every individual’s right to determine their gender identity and sex designation on government documents and other forms of government identification.
2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual’s gender identity, as reported by the individual and without need for verification by a medical professional.
3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to “male” and “female.”
4. Our AMA: (a) ~~supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates; and (b) supports that any change of sex designation on an individual’s birth certificate not hinder access to medically appropriate preventive care~~ supports efforts to ensure that the sex designation on an individual’s government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual’s needs.

4. REIMBURSEMENT FOR CARE OF PRACTICE PARTNER RELATIVES**Introduced by New York**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-390.833

RESOLVED, That our American Medical Association support changes in the Medicare guidelines to allow a physician to care for and receive appropriate reimbursement for immediate relatives of one of the colleagues in their practice.

5. RIGHT FOR GAMETE PRESERVATION THERAPIES**Introduced by New York**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policies H-65.956 and H-185.922

RESOLVED, That fertility preservation services be recognized by our American Medical Association as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies; and be it further

RESOLVED, That our AMA support the right of transgender or non-binary individuals to seek gamete preservation therapies; and be it further

RESOLVED, That our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility.

6. USE OF PERSON-CENTERED LANGUAGE**Introduced by Wisconsin**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy H-140.831

RESOLVED, That our American Medical Association encourage the use of person-centered language.

7. DELEGATION OF INFORMED CONSENT**Introduced by Resident and Fellow Section**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-160.918

RESOLVED, That our American Medical Association in cooperation with other relevant stakeholders advocate that a qualified physician, while retaining the ultimate responsibility for all aspects of the informed consent process, be able to delegate tasks associated with the process to other qualified members of the health care team who have knowledge of the patient, the patient's condition, and the procedures to be performed on the patient; and be it further

RESOLVED, That our AMA study the implications of the *Shinal v. Toms* ruling and its potential effects on the informed consent process.

8. PREVENTING ANTI-TRANSGENDER VIOLENCE

Introduced by Minority Affairs Section, GLMA: Health Professionals Advancing LGBTQ Equality

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-65.957

RESOLVED, That our American Medical Association partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; and be it further

RESOLVED, That our AMA advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; and be it further

RESOLVED, That our AMA advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; and be it further

RESOLVED, That our AMA advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and be it further

RESOLVED, That our AMA advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

9. REFERENCES TO TERMS AND LANGUAGE IN POLICIES ADOPTED TO PROTECT POPULATIONS FROM DISCRIMINATION AND HARASSMENT

Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy G-600.067

RESOLVED, That our American Medical Association undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not; and be it further

RESOLVED, That our AMA research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment; and be it further

RESOLVED, That our AMA present the preliminary study results the Minority Affairs Section, the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment; and be it further

RESOLVED, That our American Medical Association produce a report within 18 months with study results and recommendations.

10. COVENANTS NOT TO COMPETE

Introduced by New Mexico

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association consider as the basis for model legislation the New Mexico statute allowing a requirement that liquidated damages be paid when a physician partner who is a part owner in practice is lured away by a competing hospital system; and be it further

RESOLVED, That our AMA ask our Council on Ethical and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case of a physician partner who is a part owner of a practice, in light of the protection that liquidated damages can confer to independent physician owned partnerships, and because a requirement to pay liquidated damages does not preclude a physician from continuing to practice in his or her community.

11. MATURE MINOR CONSENT TO VACCINATIONS

Introduced by Michigan

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-440.830

RESOLVED, That our American Medical Association amend the policy H-440.830, "Education and Public Awareness on Vaccine Safety and Efficacy," by addition and deletion as follows:

Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; ~~and~~ (f) supports state policies allowing minors to override their parent's refusal for vaccinations and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

12. IMPROVING BODY DONATION REGULATION

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-460.890

RESOLVED, That our American Medical Association recognize the need for ethical, transparent, and consistent body and body part donation regulations.

**13. OPPOSING OFFICE OF REFUGEE RESETTLEMENT'S USE OF MEDICAL AND
PSYCHIATRIC RECORDS FOR EVIDENCE IN IMMIGRATION COURT**
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-65.958

RESOLVED, That our American Medical Association advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and be it further

RESOLVED, That our AMA condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent.

**14. DISCLOSURE OF FUNDING SOURCES AND INDUSTRY TIES OF PROFESSIONAL MEDICAL
ASSOCIATIONS AND PATIENT ADVOCACY ORGANIZATIONS**
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy G-620.043

RESOLVED, That our American Medical Association support guidelines for members of the Federation of Medicine and patient advocacy organizations to disclose donations, sponsorships, and other financial transactions by industry and commercial stakeholders.

15. OPPOSING MANDATED REPORTING OF PEOPLE WHO QUESTION THEIR GENDER IDENTITY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-65.959

RESOLVED, That our American Medical Association oppose mandated reporting of individuals who question or express interest in exploring their gender identity.

16. SEXUAL AND GENDER MINORITY POPULATIONS IN MEDICAL RESEARCH
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-315.967

RESOLVED, That our American Medical Association amend Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," by addition and deletion as follows:

H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation"

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic

health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of ~~sexual orientation/gender identity~~ sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health.

17. NATIONAL GUIDELINES FOR GUARDIANSHIP

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association collaborate with relevant stakeholders to advocate for federal creation and adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures.

18. SUPPORT FOR REQUIRING INVESTIGATIONS INTO DEATHS OF CHILDREN IN FOSTER CARE

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy H-60.904

RESOLVED, That our American Medical Association support legislation requiring investigations into the deaths of children in the foster care system that occur while the child is in the foster care system.

19. OPPOSITION TO REQUIREMENTS FOR GENDER-BASED MEDICAL TREATMENTS FOR ATHLETES

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED FOR REPORT AT THE 2019 INTERIM MEETING

RESOLVED, That our American Medical Association oppose any regulations requiring mandatory medical treatment or surgery for athletes with Differences of Sex Development (DSD) to be allowed to compete in alignment with their identity; and be it further

RESOLVED, That our AMA oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions.

20. REQUEST TO THE AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (CEJA) TO CONSIDER SPECIFIC CHANGES TO THE CODE OF MEDICAL ETHICS OPINION E-5.7, “PHYSICIAN-ASSISTED SUICIDE”, IN ORDER TO REMOVE INHERENT CONFLICTS WITHIN THE CODE, TO DELETE PEJORATIVE, STIGMATIZING LANGUAGE, AND TO ADOPT AN ETHICAL POSITION OF ENGAGED NEUTRALITY

Introduced by New Mexico, Vermont, Oregon, Colorado, California, Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association Council on Judicial and Ethical Affairs be strongly encouraged to remove from the Code of Medical Ethics Opinion E-5.7 “Physician-Assisted Suicide” judgmental, stigmatizing language that is not evidence based, is at odds with the conclusions of CEJA Report 2 in recognizing shared values of care, compassion, respect and dignity, and creates an ethical conflict with the Code of Medical Ethics Opinion E-1.1.7 “Physician Exercise of Conscience”; specifically by:

- (a) Deleting all references to “suicide”, including “Physician-assisted suicide” and replacing such language by referring to “Physician-assisted dying (PAD)”;
- (b) Deleting language that suggests that PAD is a form of doing harm and is therefore antithetical to the admonition to “do no harm”, such as “assisted suicide would ultimately cause more harm than good”;
- (c) Deleting language that characterizes PAD as a choice by a patient “that death is preferable to life” and replacing that language with a description of PAD as giving a terminally ill patient the option of being in control of the manner of his or her death, without assigning a value judgment to that option;
- (d) Deleting language that characterizes PAD as “fundamentally incompatible with the physician’s role as healer”, and instead recognizing that a physician who participates in PAD is doing so as an act of compassion and caring for patients who have no prospect of healing their fatal illness;
- (e) Delete language that suggests that PAD is not compatible with “responding to the needs of patients at the end of life” or that PAD is “abandonment”; and be it further

RESOLVED, In recognition of the fact that highly ethical physicians may have differing opinions on Physician Assisted Dying (PAD), but also in recognition of our respect for patient autonomy and the growing numbers of patients who wish to exercise choice over the manner of imminent death, that our American Medical Association’s Council on Judicial and Ethical Affairs (CEJA) be strongly encouraged to modify Code of Medical Ethics Opinion E-5.7 “Physicians-Assisted Suicide” to follow the lead of a number of state and national medical societies by adopting the ethical position of “Engaged Neutrality”, defined as neither in favor of nor in opposition to PAD, while providing reassurance that our AMA will be a resource to lawmakers, physicians and the public to ensure compliance with standards of lawful medical practice, and to protect physicians’ freedom to participate or not participate in PAD in accordance with their personal beliefs and our AMA’s Opinion E-1.1.7 “Physician Exercise of Conscience”.

21. HEALTH, IN ALL ITS DIMENSIONS, IS A BASIC HUMAN RIGHT

Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy H-65.960

RESOLVED, That our American Medical Association acknowledge that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and be it further

RESOLVED, That the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

22. OPPOSITION TO INVOLUNTARY CIVIL COMMITMENT FOR SUBSTANCE USE DISORDER
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association oppose involuntary civil commitment without judicial involvement of persons for reasons solely related to substance-use disorder; and be it further

RESOLVED, That our AMA work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services.

23. DISTRIBUTION AND DISPLAY OF HUMAN TRAFFICKING AID
INFORMATION IN PUBLIC PLACES
Introduced by Texas

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy H-440.814

RESOLVED, That our American Medical Association adopt as policy that readily visible signs, notices, posters, placards, and other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings; and be it further

RESOLVED, That our AMA, through its website or internet presence, provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same; and be it further

RESOLVED, That our AMA urge the federal government to make changes in laws to advocate for the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings.

24. ELIMINATING USE OF THE TERM “MENTAL RETARDATION” BY
PHYSICIANS IN CLINICAL SETTINGS
Introduced by Texas

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy H-70.912

RESOLVED, That our American Medical Association recommend that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings.

25. GENDER EQUITY IN HOSPITAL MEDICAL STAFF BYLAWS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy D-525.994

RESOLVED, That our American Medical Association affirm that hospital medical staff bylaws should promote, and not impede, gender equity in their implementation; and be it further

RESOLVED, That our AMA study existing hospital medical staff bylaws as to how they impact on issues of gender equity, directly or indirectly, and suggest any addition(s) to its model bylaws to assure this issue is properly addressed, and gender equity affirmed.

26. RESTRICTIVE COVENANTS OF LARGE HEALTH CARE SYSTEMS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy D-383.978

RESOLVED, That our American Medical Association, through its Organized Medical Staff Section, educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care; and be it further

RESOLVED, That our AMA study the impact that restrictive covenants have across all practice settings, including but not limited to the effect on patient access to health care, the patient-physician relationship, and physician autonomy, with report back at the 2019 Interim Meeting.

27. MODEL LEGISLATION FOR "MATURE MINOR" CONSENT TO VACCINATIONS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED

See Policy D-440.926

RESOLVED, That our American Medical Association support physicians in assessing whether a minor has met maturity and medical decision-making capacity requirements when providing consent for vaccinations and in developing protocols for appropriate documentation; and be it further

RESOLVED, That our AMA develop model legislation to aid states in developing their own policies to allow “mature minors”, defined as “certain older minors who have the capacity to give informed consent to do so for care that is within the mainstream of medical practice, not high risk, and provided in a nonnegligent manner,” to self-consent for vaccinations.

101. HEALTH HAZARDS OF HIGH DEDUCTIBLE INSURANCE**Introduced by Indiana***Reference committee hearing: see report of Reference Committee A.***HOUSE ACTION: POLICIES H-165.828, H-165.846 AND D-185.979
REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support health insurance deductibles of not more than \$1,000 for an individual per year, especially to patients with significant chronic disease.

102. USE OF HSAs FOR DIRECT PRIMARY CARE**Introduced by Illinois***Reference committee hearing: see report of Reference Committee A.***HOUSE ACTION: ADOPTED**
See Policy H-385.912

RESOLVED, That our American Medical Association adopt policy that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense; and be it further

RESOLVED, That our AMA seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use Health Savings Accounts (HSAs) to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.

103. HEALTH SYSTEM IMPROVEMENT STANDARDS**Introduced by New York***Considered on reaffirmation calendar.***HOUSE ACTION: POLICIES H-165.838, H-165.846, H-270.962, H-285.904, H-285.908 AND H-385.946
REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for health care reform proposals that would achieve the following:

- Reduce the number of uninsured; and
- Reduce barriers to insured patients receiving needed health care, including ensuring full transparency of patient-cost sharing requirements, preventing unjustified denials of coverage, ensuring comprehensive physician networks, including through fair reimbursement methodologies, and providing meaningful coverage for out-of-network care; and
- Reduce administrative burden on physicians; and
- Prevent imposition of new costs or unfunded mandates on physicians; and
- Provide needed tort reform; and
- Provide meaningful collective negotiation rights for physicians.

104. ADVERSE IMPACTS OF SINGLE SPECIALTY INDEPENDENT PRACTICE ASSOCIATIONS
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-285.973, H-285.984, H-285.992 AND D-285.972 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association conduct a study relating to the impact of managed care plans replacing their participating physicians with those of a non-primary care physician single specialty independent practice association.

105. PAYMENT FOR BRAND MEDICATIONS WHEN THE GENERIC MEDICATION IS RECALLED

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
See Policies H-100.956, H-110.987 and H-125.975

RESOLVED, That our AMA support health plans and pharmacy benefit managers providing a process for expedited formulary exceptions in the event of a recall of a generic medication, to ensure patient access to the brand medication or more affordable, alternative treatment options; and be it further

RESOLVED, That our AMA reaffirm Policy H-110.987, which supports the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage or no available comparable generic drug; and be further

RESOLVED, That our AMA reaffirm Policy H-100.956, which outlines policy priorities to respond to national drug shortages.

106. RAISING MEDICARE RATES FOR PHYSICIANS
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-390.953 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate strongly for raising the Medicare Fee Schedules for physicians.

107. INVESTIGATE MEDICARE PART D – INSURANCE COMPANY UPCHARGE
Introduced by Ohio

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-330.874

RESOLVED, That our AMA support a US Government Accountability Office (GAO) study of Medicare Part D plan risk assessment behaviors and strategies, and their impact on direct subsidy, reinsurance subsidy and risk corridor payments.

108. CONGRESSIONAL HEALTHCARE PROPOSALS**Introduced by Ohio***Considered on reaffirmation calendar.***HOUSE ACTION: POLICIES H-165.838, H-165.881, H-165.985 AND H-373.998 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support provisions in Federal legislation that:

1. Do not limit the choices available for Americans for health care coverage
2. Support improving existing health plans
3. Make any new plan voluntary
4. Do not eliminate the private insurance market.

109. PART A MEDICARE PAYMENT TO PHYSICIANS**Introduced by Ohio***Reference committee hearing: see report of Reference Committee A.***HOUSE ACTION: ADOPTED***See Policy D-390.948*

RESOLVED, That our American Medical Association work for enactment of legislation to direct cash payments from Part A Medicare to physicians in direct proportion to demonstrated savings that are made in Part A Medicare through the efforts of physicians.

110. ESTABLISHING FAIR MEDICARE PAYER RATES**Introduced by Ohio***Considered on reaffirmation calendar.***HOUSE ACTION: POLICY D-400.990 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association pursue Centers for Medicare and Medicaid Services (CMS) intervention and direction to prevent commercial Medicare payers from compensating physicians at rates below Medicare's established rates.

111. PRACTICE OVERHEAD EXPENSE AND THE SITE-OF-SERVICE DIFFERENTIAL**Introduced by Ohio***Reference committee hearing: see report of Reference Committee A.***HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, That our American Medical Association appeal to the US Congress for legislation to direct the Centers for Medicare and Medicaid Services (CMS) to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office; and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by

means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense; and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.

112. HEALTH CARE FEE TRANSPARENCY **Introduced by Oklahoma**

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-105.988, H-373.998 AND D-155.987 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for federal legislation and/or regulation to require disclosure of hospital prices negotiated with insurance companies in effort to achieve third-party contract transparency; and be it further

RESOLVED, That our AMA advocate for federal legislation and/or regulation to require pharmaceutical companies to disclose drug prices in their television (TV) ads in order to provide consumers more choice and control over their healthcare.

113. ENSURING ACCESS TO STATEWIDE COMMERCIAL HEALTH PLANS **Introduced by Washington, Connecticut, Rhode Island, Massachusetts, Vermont, Maine, New Hampshire**

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association study the concept of offering state employee health plans to every state resident, including exchange participants qualifying for federal subsidies, and report back to the House of Delegates this year; and be it further

RESOLVED, That our AMA advocate that State Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity.

114. ENSURING ACCESS TO NATIONWIDE COMMERCIAL HEALTH PLANS **Introduced by Washington, Connecticut**

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate that Federal Employees Health Benefits Program health insurance plans should become available to everyone to purchase at actuarially appropriate premiums as well as be eligible for federal premium tax credits; and be it further

RESOLVED, That our AMA advocate that Federal Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity.

115. SAFETY OF DRUGS APPROVED BY OTHER COUNTRIES

Reference committee hearing: see report of Reference Committee A.

**HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTIONS 115 AND 129**

See Policies D-100.983 and D-100.985

RESOLVED, That our AMA support the personal importation of prescription drugs only if:

- a. patient safety can be assured;
- b. product quality, authenticity and integrity can be assured;
- c. prescription drug products are subject to reliable, “electronic” track and trace technology; and
- d. prescription drug products are obtained directly from a licensed foreign pharmacy, located in a country that has statutory and/or regulatory standards for the approval and sale of prescription drugs that are comparable to the standards in the United States; and be it further

RESOLVED, That our AMA reaffirm Policy D-100.983, which guides AMA advocacy with respect to the prescription drug importation by wholesalers and pharmacies; and be it further

RESOLVED, That our AMA reaffirm D-100.985, which states that our AMA will continue to actively oppose illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting.

**116. MEDICARE FOR ALL
Introduced by Wisconsin****Resolution 116 was considered with Council on Medical Service Report 2.
See Council on Medical Service Report 2.**

RESOLVED, That our American Medical Association gather current, accurate data on the reimbursement from Medicare for private practice physicians, medical clinics, hospital outpatient services, hospitals including rural hospitals and critical access hospitals, and healthcare systems along with accurate data as to how the reimbursement compares to the cost for providing the medical care for these services; and be it further

RESOLVED, That our AMA evaluate what would happen to the healthcare economics of the United States and the ability to continue outpatient medical practice if the current Medicare reimbursement, compared to the cost of providing that care, became the major financing resource for medical care and predict what effect this would have on the access to medical care in the U.S.; and be it further

RESOLVED, That our AMA evaluate how the current differential payments in Medicare to various entities for the same service would change in a “Medicare for all” scenario; and be it further

RESOLVED, That our AMA, after analysis of the data, provide to the patients and physicians of our country the relevant questions that we can ask of political candidates advocating “Medicare for all” and; and be it further

RESOLVED, That our AMA provide a better understanding of the impact of “Medicare for all” in terms of healthcare financing, workforce, ability to continue private practice medical care, incentives for physicians to join hospital systems, availability of care, and help understand how this might change the provision of healthcare in the United States.

117. SUPPORT FOR MEDICARE COVERAGE OF CONTRACEPTIVE METHODS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-330.900

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and other stakeholders to include coverage for all US Food and Drug Administration-approved contraceptive methods for contraceptive and non-contraceptive use for all patients covered by Medicare, regardless of eligibility pathway (age or disability).

118. PHARMACEUTICAL PRICING TRANSPARENCY
Introduced by Oklahoma

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-110.987, H-110.991, H-125.979 AND H-125.986 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association lobby for legislation that requires Pharmacy Benefit Managers to enhance drug-pricing transparency for the benefit of patients.

119. RETURNING LIQUID OXYGEN TO FEE SCHEDULE PAYMENT
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-330.873

RESOLVED, That our American Medical Association support policy to remove liquid oxygen from the competitive bidding system and return payments for liquid oxygen to a Medicare fee schedule basis.

120. MEDICARE COVERAGE OF HEARING AIDS
Introduced by Georgia

Resolution 120 was considered with Resolution 124. See Resolution 124.

RESOLVED, That our American Medical Association urge Medicare to cover some or all of the costs of a "reasonable" device for both ears if a patient has had an audiological exam that identifies the need, and for Medicare to identify a vendor, or vendors, of hearing devices that produce a quality product without an exorbitant retail price.

121. MAINTENANCE HEMODIALYSIS FOR UNDOCUMENTED PERSONS**Introduced by Michigan***Considered on reaffirmation calendar.***HOUSE ACTION: POLICIES H-160.956, H-350.957 AND D-440.985 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to identify and advocate for equitable health care options to provide scheduled maintenance hemodialysis to undocumented persons.

122. REIMBURSEMENT FOR TELEHEALTH**Introduced by Michigan***Reference committee hearing: see report of Reference Committee A.***HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-480.965**

RESOLVED, That our American Medical Association work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians.

**123. STANDARDIZING COVERAGE OF APPLIED BEHAVIORAL ANALYSIS THERAPY
FOR PERSONS WITH AUTISM SPECTRUM DISORDER****Introduced by Medical Student Section***Reference committee hearing: see report of Reference Committee A.***HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-185.921**

RESOLVED, That our American Medical Association support coverage and reimbursement for evidence-based treatment of Autism Spectrum Disorder including, but not limited to, Applied Behavior Analysis Therapy.

124. INCREASED AFFORDABILITY AND ACCESS TO HEARING AIDS AND RELATED CARE**Introduced by Medical Student Section***Reference committee hearing: see report of Reference Committee A.***HOUSE ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 120
See Policy H-185.929**

RESOLVED, That our American Medical Association support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly; and be it further

RESOLVED, That our AMA encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and be it further

RESOLVED, That our AMA support the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

125. MITIGATING THE NEGATIVE EFFECTS OF HIGH-DEDUCTIBLE HEALTH PLANS

Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments.

126. ENSURING PRESCRIPTION DRUG PRICE TRANSPARENCY FROM RETAIL PHARMACIES

Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-110.991

RESOLVED, That our American Medical Association amend Policy H-110.991, “Price of Medicine,” by addition and deletion as follows:

Our AMA:

- (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications;
- (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication;
- (3) opposes provisions in pharmacies’ contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient’s co-pay is higher than the drug’s cash price;
- (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit “clawbacks” ~~and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less expensive options for purchasing their medication; and~~
- (5) supports physician education regarding drug price and cost transparency, manufacturers’ pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and
- (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare’s drug-pricing dashboard.

127. ELIMINATING THE CMS OBSERVATION STATUS

Introduced by New Jersey

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED

See Policy D-280.984

RESOLVED, That our American Medical Association request, for the benefit of our patients’ financial, physical and mental health, that the Centers for Medicare and Medicaid Services terminate the “48 hour observation period” and observation status in total.

128. ELIMINATION OF CMS HOSPITAL READMISSION PENALTIES**Introduced by New Jersey***Considered on reaffirmation calendar.***HOUSE ACTION: POLICY H-340.989 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association immediately write a letter to the Centers for Medicare and Medicaid Services and Congress with the goal of working together to remove the financial penalty for any cause readmissions to a hospital; and be it further

RESOLVED, That our AMA reaffirm Policy H-340.989, “PRO Readmission Review.”

129. THE BENEFITS OF IMPORTATION OF INTERNATIONAL PHARMACEUTICAL MEDICATIONS**Introduced by Texas**

Resolution 129 was considered with resolution 115. See resolution 115.

RESOLVED, That our American Medical Association study the implications of prescription drug importation for personal use and wholesale prescription drug purchase across our southern and northern borders.

130. NOTIFICATION OF GENERIC DRUG MANUFACTURING CHANGES**Introduced by Texas***Considered on reaffirmation calendar.***HOUSE ACTION: POLICY H-115.974 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association lobby Congress to pass legislation that ensures that each patient is expressly notified at the time of dispensing by the pharmacy or pharmacy benefit manager of a change in the manufacturer of his or her generic medication.

131. UPDATE PRACTICE EXPENSE COMPONENT OF RELATIVE VALUE UNITS**Introduced by Texas***Reference committee hearing: see report of Reference Committee A.***HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, That our American Medical Association pursue efforts to update resource-based relative value unit practice expense methodology so it accurately reflects current physician practice costs, with a report back at the AMA House of Delegates 2019 Interim Meeting.

132. SITE OF SERVICE DIFFERENTIAL**Introduced by Charles Rothberg, MD, Delegate; and Thomas J. Madejski, MD, Delegate***Reference committee hearing: see report of Reference Committee A.***HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, That our American Medical Association advocate for site of service payment equalization to be calculated in a manner that both enhances physician reimbursement while maintaining hospital rates for physician services at an objectively justifiable level, including but not limited to the filing of amicus briefs in relevant lawsuits as determined appropriate by the Office of General Counsel.

201. ASSURING PATIENT ACCESS TO KIDNEY TRANSPLANTATION**Introduced by American Society of Transplant Surgeons***Reference committee hearing: see report of Reference Committee B.***HOUSE ACTION: ADOPTED AS FOLLOWS***See Policy D-370.983*

RESOLVED, That our American Medical Association work with professional and patient-centered organizations to advance patient and physician-directed coordinated care for End Stage Renal Disease (ESRD) patients; and be it further

RESOLVED, That our AMA actively oppose any legislative or regulatory efforts to remove patient choice and physician involvement in ESRD care decisions; and be it further

RESOLVED, That our AMA actively oppose any legislative or regulatory effort that would create financial incentives that would curtail the access to kidney transplantation; and be it further

RESOLVED, That our AMA House of Delegates be advised in a timely fashion regarding any legislative or regulatory efforts to abrogate patient and physician-advised decision-making regarding modality of care for ESRD.

202. REDUCING THE HASSLE FACTOR IN QUALITY IMPROVEMENT PROGRAMS**Introduced by California***Considered on reaffirmation calendar.***HOUSE ACTION: POLICIES D-275.954 AND D-395.999 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association recommend to the Centers for Medicare and Medicaid Services (CMS) and physician certifying boards, such as the American Board of Medical Specialties, that maintenance of certification (MOC) participation count toward satisfying the quality category of the Merit-Based Incentive Payment Program (MIPS); and be it further

RESOLVED, That our AMA also recommend that successful reporting in the quality category of the Merit-Based Incentive Payment Program (MIPS) count toward satisfying the practice performance assessment section of a certifying board's MOC requirements; and be it further

RESOLVED, That our AMA study MOC and Medicare MIPS reciprocity and work with the state and national specialty societies to develop a plan to reduce quality measure duplication and administrative burdens in both the MIPS and MOC programs.

203. MEDICARE PART B AND PART D DRUG PRICE NEGOTIATION
Introduced by California

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate for Medicare to cover all physician-recommended adult vaccines in both the Medicare Part D and the Medicare Part B programs; and be it further

RESOLVED, That our AMA make it a priority to advocate for a mandate on pharmaceutical manufacturers to negotiate drug prices with the Centers for Medicare and Medicaid Services for Medicare Part D and Part B covered drugs; and be it further

RESOLVED, That our AMA explore all options with the state and national specialty societies to ensure that physicians have access to reasonable drug prices for the acquisition of Medicare Part B physician-administered drugs and that Medicare reimburse physicians for their actual drug acquisition costs, plus appropriate fees for storage, handling, and administration of the medications, to ensure access to high-quality, cost-effective care in a physician's office.

**204. HOLDING THE PHARMACEUTICAL INDUSTRY ACCOUNTABLE FOR
OPIOID-RELATED COSTS**
Introduced by California

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-95.918

RESOLVED, That our American Medical Association advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation against pharmaceutical manufacturers, distributors or other entities alleged to have engaged in unethical and deceptive misbranding, marketing, and advocacy of opioids, be used exclusively for research, education, prevention and treatment of overdose, opioid use disorder and pain.

**205. USE OF PATIENT OR CO-WORKER EXPERIENCE/SATISFACTION SURVEYS TIED
TO EMPLOYED PHYSICIAN SALARY**
Introduced by Illinois

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES H-275.924, H-450.982 AND D-385.958 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association adopt policy opposing any association between anonymous patient satisfaction scores (e.g. "loyalty scores") or the coworkers' observation reporting system, and employed physicians' salaries; and be it further

RESOLVED, That our AMA adopt policy opposing any publication of anonymous patient satisfaction scores or coworkers' observation reporting system information directed at an individual physician; and be it further

RESOLVED, That our AMA adopt policy opposing the use of any anonymous patient satisfaction scores or any individually and anonymously posted patient or co-worker comments in formulating or impacting employed physician salaries or in relation to any other physician compensation program.

206. CHANGING THE PARADIGM: OPPOSING PRESENT AND OBVIOUS RESTRAINT OF TRADE
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: POLICIES H-165.833, H-180.975, H-380.987, H-383.988, H-383.990, H-383.992, H-383.993, H-385.946, H-385.973, H-385.976, D-383.981, D-383.982, D-383.983, D-383.985, D-383.988 AND D-383.990 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association seek legislative or regulatory changes to allow physicians to collectively negotiate professional fees, compensation and contract terms without integration.

207. DIRECT-TO-CONSUMER GENETIC TESTS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association regard research using consumer genome data derived from saliva or cheek swab samples as research on human subjects requiring consents in compliance with the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an “opt in” option to allow more consumer choice in the consent process; and be it further

RESOLVED, That our AMA amend Policy H-315.983, “Patient Privacy and Confidentiality,” by addition to align with current research and privacy infringement findings, as follows:

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received, while working with the Department of Health and Human Services (HHS) to stop the transfer of birthdates and state of residence by genetic testing companies and their affiliates, unless there is explicit user approval, to prevent re-identification of the test user by way of surname inference methods.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the

consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. Our AMA regards studies using consumer genome data derived from saliva, cheek swab, or other human tissue samples as research on human subjects requiring consents in compliance with the HHS Office for Human Research Protections (OHRP). An "opt in" option is recommended to allow more consumer choice in the consent process.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. The AMA will work with Congress and HHS to modify the Genetic Information Nondiscrimination Act of 2008 (GINA), which bans genome-based policy and hiring decisions by health insurance companies and employers, by adding Long-Term Care, Life Insurance, and Disability Insurance to the Act to prevent applicant rejection based on their genetic makeup.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

a. Our AMA supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identified information with other parties without the consent of the user. An exception would be made when requested by law enforcement authorities or when keeping the information would seriously threaten their health or that of others. If a data security breach occurs with the Direct-To –Consumer genetic company or its collaborators, then the company has the responsibility to inform all users of the breach and the impact of the unprotected private data on those individuals;

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation; and be it further

RESOLVED, That our AMA work with the Department of Health and Human Services or other relevant parties to modify the rules to prevent genetic testing entities from transferring information about the user's date of birth and state of residence to third parties which may result in the re-identification of the user based on surname inference; and be it further

RESOLVED, That our AMA work with Congress and the Department of Health and Human Services to extend the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California.

208. MODIFICATION OF THE SUNSHINE ACT
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-140.848

RESOLVED, That our AMA 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.

209. MANDATES BY ACOs REGARDING SPECIFIC EMR USE
Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-160.915, D-478.972 AND D-478.995 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association adopt policy stating that Accountable Care Organizations cannot mandate their membership to use a single specific Electronic Medical Record (EMR); and be it further

RESOLVED, That our AMA move to effect legislation that prevents Accountable Care Organizations from imposing EMR mandates.

210. AIR AMBULANCES
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-285.904 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support federal legislation which would:

1. Establish an expedited independent dispute resolution system to resolve payment disputes between emergency air ambulance providers and health insurers; and
2. Ensure that such independent dispute resolution process would ensure the patient be “held harmless” except for applicable insurance policy in-network cost-sharing requirements.

211. OUT-OF-NETWORK PAYMENT DATABASE
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-285.904

RESOLVED, That our American Medical Association advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

212. CONTINUITY OF CARE FOR PATIENTS DISCHARGED FROM A HOSPITAL SETTING**Introduced by New York***Reference committee hearing: see report of Reference Committee B.***HOUSE ACTION: ADOPTED AS FOLLOWS****TITLE CHANGED****PROPOSED ADDITIONAL RESOLVE REFERRED***See Policy H-85.955*

RESOLVED, That our American Medical Association advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.

The following proposed resolve was referred:

RESOLVED, That our AMA advocate to ensure that medications prescribed during hospitalization with ongoing indications for the outpatient and other non-hospital-based care settings continue to be covered by pharmacy benefit management companies, health insurance companies, and other payers after hospital discharge.

213. FINANCIAL PENALTIES AND CLINICAL DECISION-MAKING**Introduced by New York***Reference committee hearing: see report of Reference Committee B.***HOUSE ACTION: ADOPTED AS FOLLOWS***See Policy H-180.942*

RESOLVED, That our American Medical Association oppose the practice of a payer utilizing statistical targets alone (and not outcomes data) to determine ‘cost effectiveness’ of a therapeutic choice; and be it further

RESOLVED, That our AMA oppose the practice of a payer imposing financial penalties upon patients, physicians and/or associated physicians based upon the use of statistical targets without first considering the clinical factors unique to each patient’s claim.

214. DEFINITION AND USE OF THE TERM PHYSICIAN*Reference committee hearing: see report of Reference Committee B.***HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTIONS 214 AND 216***See Policy H-405.951*

RESOLVED, That our AMA

1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
 - a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
 - b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and

- c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.
7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign; and be it further

RESOLVED, That Policies H-405.969, H-405.976, D-405.989, H-330.986 and H-405.968 be rescinded.

215. REIMBURSEMENT FOR HEALTH INFORMATION TECHNOLOGY

Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-478.981 AND D-478.996 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek the passage of federal regulation and/or legislation that mandates that third party payers allow physician practices to charge a technology fee equal to the copayment of the patient's plan.

216. ELIMINATE THE WORD “PROVIDER” FROM HEALTHCARE CONTRACTS

Introduced by New York

Resolution 216 was considered with Resolution 214. See Resolution 214.

RESOLVED, That our American Medical Association seek legislation to ensure that all references to physicians in government and insurance contracts, agreements, published descriptions, and printed articles eliminate the word “provider” and substitute the accurate and proper term “physician”.

217. MEDICARE VACCINE BILLING

Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS *See Policy D-440.981*

RESOLVED, That our American Medical Association advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.

218. IMPROVED ACCESS AND COVERAGE TO NON-OPIOID MODALITIES TO ADDRESS PAIN

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTIONS 218 AND 235
PROPOSED ADDITIONAL RESOLVES REFERRED**
See Policy H-120.922

RESOLVED, That our American Medical Association advocate for increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient's physician; and be it further

RESOLVED, That our AMA advocate for non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force; and be it further

RESOLVED, That our AMA encourage the manufacturers of pharmaceutical pain care options to seek United States Food and Drug Administration approval for additional indications related to non-opioid pain management therapy.

The following proposed resolves were referred:

RESOLVED, That although our AMA supports all interventional pain interventions and therapies in general, due to current issues with limitations in coverage and noncoverage, in particular, spine and large joint radiofrequency ablation and other arbitrarily limited non-covered interventional pain management procedures, by private insurance carriers, third party reviewing agencies, Medicare and Medicaid contractors, and Medicare Advantage Plans, the AMA supports coverage of these medically necessary procedures in particular, at this time, and be it further

RESOLVED, That our AMA supports coverage of evidence-based spinal cord stimulation trials and implantation, and peripheral nerve stimulation trials and implantation (as both CPT code sets are linked to their respective ICD-10 codes as outlined in the AMA CPT Manual) by private insurance carriers, third party reviewing agencies, Medicare and Medicaid contractors, and Medicare Advantage Plans.

219. MEDICAL MARIJUANA LICENSE SAFETY
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association draft model state legislation to amend states' prescription drug monitoring programs to include a medical marijuana license registry.

**220. CONFIDENTIALITY AND PRIVACY PROTECTIONS ENSURING CARE COORDINATION
AND THE PATIENT-PHYSICIAN RELATIONSHIP**

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTIONS 220 AND 231**

See Policy H-315.964

RESOLVED, That our American Medical Association support the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state law for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of “Part 2” substance use disorder records in criminal proceedings; and be it further

RESOLVED, That our AMA support the sharing of substance use disorder patient records as required by the HIPAA Privacy Rule and as applies to state law for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care.

221. EXTENDING MEDICAID COVERAGE FOR ONE YEAR POSTPARTUM

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTIONS 221 AND 224**

See Policy D-290.974

RESOLVED, That our American Medical Association work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.

**222. PROTECTING PATIENTS FROM MISLEADING AND POTENTIALLY
HARMFUL "BAD DRUG" ADS**

Introduced by Kentucky, Mississippi, Oklahoma, West Virginia

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES H-105.985 AND H-315.978 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association encourage state legislatures to consider and adopt legislation that helps protect patient health by creating fair rules and regulations around attorney advertisements that:

1. Prohibit misuse of governmental logos or the term “recall”
2. Provide clear warning of the dangers in stopping a course of treatment without consulting with a physician and
3. Require written consent before sharing personal health information.

**223. SIMPLIFICATION AND CLARIFICATION OF SMOKING STATUS DOCUMENTATION
IN THE ELECTRONIC HEALTH RECORD**
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED

See Policy H-478.990

RESOLVED, That our American Medical Association support the streamlining of the SNOMED categories for smoking status and passive smoking exposure documentation in the electronic medical record so that the categories are discrete, non-overlapping, and better understood per The Association for the Treatment of Tobacco Use and Dependence 2019 recommendations as follows:

Smoking status categories: Current Every Day Smoker, Current Some Day Smoker Former Smoker, Never Smoker, and Smoking Status Unknown.

Passive smoking exposure: Exposure to Second Hand Tobacco Smoke, Past Exposure to Second Hand Tobacco Smoke, No Known Exposure to Second Hand Tobacco Smoke.

224. EXTENDING PREGNANCY MEDICAID TO ONE YEAR POSTPARTUM
Introduced by Resident and Fellow Section

Resolution 224 was considered with Resolution 221. See Resolution 221.

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services to extend pregnancy Medicaid to a minimum of one year postpartum.

225. DACA IN GME
Introduced by Resident and Fellow Section

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES H-255.988, D-200.985, D-255.980, D-255.991 AND D-350.986
REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That American Medical Association Policy D-255.991, “Visa Complications for IMGs in GME,” be reaffirmed; and be it further

RESOLVED, That AMA Policy D-350.986, “Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages,” be reaffirmed.

226. PHYSICIAN ACCESS TO THEIR MEDICAL AND BILLING RECORDS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination; and be it further

RESOLVED, That our AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to the medical and billing records such as treating these records as trade secrets or proprietary.

227. CONTROLLED SUBSTANCE MANAGEMENT

Introduced by Alabama

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services (CMS) and interested physician groups to strongly advocate for a mechanism by which physicians may be compensated for controlled substance management; and be it further

RESOLVED, That our AMA strongly encourage CMS and private payers to recognize and establish equitable payment for controlled substance management.

228. TRUTH IN ADVERTISING

Introduced by American Society of Anesthesiologists, Texas, Virginia, Illinois, Arizona, Mississippi, Oklahoma, South Carolina, Washington, American Society of Interventional Pain Physicians

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policies H-405.964 and H-405.969

RESOLVED, That our American Medical Association reaffirm support of the Scope of Practice Partnership's Truth in Advertising Campaign to ensure patients receive accurate information about who is providing their care (AMA Policy H-405.969); and be it further

RESOLVED, That our AMA oppose any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers' state-issued licenses.

229. CLARIFICATION OF CDC OPIOID PRESCRIBING GUIDELINES

Introduced by American Society of Clinical Oncology

Resolution 229 was considered with Board of Trustees Report 22.

See Board of Trustees Report 22.

RESOLVED, That our American Medical Association reaffirm Policy D-120.932, "Inappropriate Use of Centers for Disease Control and Prevention Guidelines for Prescribing Opioids;" and be it further

RESOLVED, That our AMA incorporate into their advocacy that clinical practice guidelines specific to cancer treatment, palliative care, and end of life be utilized in lieu of the CDC's Guideline for Prescribing Opioids for Chronic Pain as per the CDC's clarifying recommendation.

**230. STATE LEGISLATION MANDATING ELECTROCARDIOGRAM (ECG) AND/OR
ECHOCARDIOGRAM SCREENING OF SCHOLASTIC ATHLETES**

**Introduced by American College of Cardiology, American Society of Echocardiography,
Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions**

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICY H-373.995 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association and state and specialty medical societies oppose legislation mandating echocardiograms or ECGs as a condition of participation in scholastic sports.

**231. ALIGNMENT OF FEDERAL PRIVACY LAW AND REGULATIONS GOVERNING SUBSTANCE
USE DISORDER TREATMENT (42 CFR PART 2) WITH THE HEALTH INSURANCE
PORTABILITY AND ACCOUNTABILITY ACT**

**Introduced by American Psychiatric Association, American Society of Addiction Medicine,
American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law,
American Association for Geriatric Psychiatry, American Academy of Physical Medicine and Rehabilitation,
American Association of Neurological Surgeons, Congress of Neurological Surgeons,
American Clinical Neurophysiology Society, American College of Physicians, Colorado,
Vermont, Washington, Wisconsin, Illinois**

Resolution 231 was considered with Resolution 220. See Resolution 220.

RESOLVED, That our American Medical Association support the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of “Part 2” substance use disorder records in criminal proceedings; and be it further

RESOLVED, That our AMA support the sharing of substance use disorder patient records as required by the HIPAA Privacy Rule for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care.

**232. COPD NATIONAL ACTION PLAN
Introduced by American Thoracic Society**

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-440.815

RESOLVED, That our American Medical Association support funding for the National Heart, Lung, and Blood Institute (NHLBI) and the Centers for Disease Control and Prevention for the purpose of implementing the Chronic Obstructive Pulmonary Disease (COPD) National Action Plan.

233. GME CAP FLEXIBILITY**Introduced by Georgia***Reference committee hearing: see report of Reference Committee B.***HOUSE ACTION: POLICY D-305.967, PARAGRAPH 31 AMENDED AS FOLLOWS
IN LIEU OF RESOLUTION 233**

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services ~~for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap setting deadline for new residency programs in underserved areas and/or economically depressed areas~~ to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

234. IMPROVED ACCESS TO NON-OPIOID THERAPIES**Introduced by Michigan***Considered on reaffirmation calendar.***HOUSE ACTION: POLICIES H-95.930, H-185.931, D-160.981 AND D-450.956 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to improve access to non-opioid treatment modalities including, but not limited to, physical therapy and occupational therapy as recommended by the patient’s physician.

235. PRESCRIPTION COVERAGE OF THE LIDOCAINE TRANSDERMAL PATCH**Introduced by Michigan****Resolution 235 considered with Resolution 218. See Resolution 218.**

RESOLVED, That our American Medical Association encourage the US Food and Drug Administration to consider approving other indications in addition to post-herpetic neuralgia for transdermal lidocaine patches; and be it further

RESOLVED, That our AMA urge the Centers for Medicare and Medicaid Services and third-party payers to provide insurance coverage of lidocaine transdermal patches for other indications in addition to post-herpetic neuralgia.

236. SUPPORT FOR UNIVERSAL BASIC INCOME PILOT STUDIES**Introduced by Medical Student Section***Reference committee hearing: see report of Reference Committee B.***HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association support federal, state, local, and/or private Universal Basic Income pilot studies in the United States which intend to measure health outcomes and access to care for participants.

237. OPPORTUNITIES IN BLOCKCHAIN FOR HEALTHCARE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-478.962

RESOLVED, That our American Medical Association work with public or private sector standard-setting organizations to create standards for the development and implementation of blockchain technologies in healthcare; and be it further

RESOLVED, That our AMA monitor the evolution of blockchain technologies in healthcare and engage in discussion with appropriate stakeholders regarding blockchain development.

**238. COVERAGE LIMITATIONS AND NON-COVERAGE OF INTERVENTIONAL PAIN
PROCEDURES CORRELATING TO THE WORSENING OPIOID
EPIDEMIC AND PUBLIC HEALTH CRISIS**
Introduced by North American Neuromodulation Society

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES H-95.930, H-185.931, D-160.981 AND D-450.956 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support coverage of sacroiliac joint blocks and radiofrequency ablation, facet (spine joint) medial branch blocks and radiofrequency ablation, genicular blocks and radiofrequency ablation for non-operable knee arthritis or pain, femoral and obturator nerve blocks and radiofrequency ablations for non-operable hip arthritis or pain, suprascapular nerve blocks and radiofrequency ablations for non-operable shoulder arthritis or pain, and other arbitrarily limited non-covered interventional pain management procedures, by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans, and be it further

RESOLVED, That our AMA support coverage of spinal cord stimulation trials and implantation, and peripheral nerve stimulation trials and implantation by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans by ICD-10 codes that have been linked to the respective Current Procedural Terminology (CPT) code set as outlined in the AMA CPT Manual.

239. IMPROVING ACCESS TO MEDICAL CARE THROUGH TAX TREATMENT OF PHYSICIANS
Introduced by Gregory Pinto, MD, Delegate

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association seek legislation and/or regulation that would permit physician practices to utilize ‘pass through’ tax treatment of practice income in the manner of other small businesses and professionals.

240. FORMATION OF COLLECTIVE BARGAINING WORKGROUP**Introduced by Hawaii***Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: POLICIES H-165.833, H-180.975, H-380.987, H-383.988, H-383.990, H-383.992, H-383.993, H-385.946, H-385.973, H-385.976, D-383.981, D-383.982, D-383.983, D-383.985, D-383.988 AND D-383.990 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association form a workgroup to outline the legal challenge to federal antitrust statute for physicians; and be it further

RESOLVED, That this workgroup engage the state medical associations and other physician groups as deemed appropriate; and be it further

RESOLVED, That our AMA report by the 2020 Annual Meeting on the viability of a strategy for the formation of a federal collective bargaining system for all physicians and, to the extent viable, a related organizational plan.

241. FACILITATION OF RESEARCH WITH MEDICARE CLAIMS DATA**Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont***Reference committee hearing: see report of Reference Committee B.*

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-406.993

RESOLVED, That our American Medical Association, in an effort to advance the feasibility of population health research to fulfill the promise of value based care, request that the Centers for Medicare and Medicaid Services (CMS) eliminate the prohibitions on sharing data outside of any CMS model including Accountable Care Organizations that are contained in the CMS Data Use Agreement and allow sharing of that data: (1) in the form of de-identified data sets as permitted by federal, state and local privacy laws; and (2) for purposes of research as permitted by federal, state and local privacy laws.

**242. IMPROVING HEALTH INFORMATION TECHNOLOGY PRODUCTS TO
PROPERLY CARE FOR LGBTQ PATIENTS****Introduced by Texas***Reference committee hearing: see report of Reference Committee B.*

HOUSE ACTION: ADOPTED

See Policy H-315.967

RESOLVED, That our American Medical Association research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; and be it further

RESOLVED, That our AMA investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and be it further

RESOLVED, That our AMA advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

243. IMPROVING THE QUALITY PAYMENT PROGRAM AND PRESERVING PATIENT ACCESS

Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association strongly advocate for Congress to make participation in the Merit-Based Incentive Payment System and alternative payment models under the Quality Payment Program completely voluntary; and be it further

RESOLVED, That our AMA strongly advocate for Congress to eliminate budget neutrality in the Merit-Based Incentive Payment System and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians; and be it further

RESOLVED, That our AMA call on the Centers for Medicare & Medicaid Services (CMS) to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so physicians and medical societies can analyze the data to advocate for additional exemptions; flexibilities; and reductions in reporting burdens, administrative hassles, and costs; and be it further

RESOLVED, That our AMA advocate that CMS increase the low-volume threshold for the 2020 Quality Payment Program and future years of the program for all physicians and continue to offer them the opportunity to opt in or voluntarily report; and be it further

RESOLVED, That our AMA reaffirm Policy H-390.838, “MIPS and MACRA Exemption,” and advocate to preserve patient access by exempting small practices (one to 15 clinicians) from required participation in the Merit-Based Incentive Payment System and continue to offer them the opportunity to opt in or voluntarily report.

244. EHR-INTEGRATED PRESCRIPTION DRUG MONITORING PROGRAM RAPID ACCESS

Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED

See Policy H-95.920

RESOLVED, That our American Medical Association advocate, at the state and national levels, to promote Prescription Drug Monitoring Program (PDMP) integration/access within Electronic Health Record workflows (of all developers/vendors) at no cost to the physician or other authorized health care provider.

245. SENSIBLE APPROPRIATE USE CRITERIA IN MEDICARE

Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association Policy H-320.940, “Medicare's Appropriate Use Criteria Program,” be amended by addition as follows:

Our AMA will continue to advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid Services can adequately address technical and workflow challenges with its implementation and any interaction between the Quality Payment Program (QPP) and the use of advanced diagnostic imaging appropriate use criteria, and support regulatory change that resolves technical and workflow challenges and/or removes barriers to modifying or aligning the AUC Program and the QPP.

**246. CALL FOR TRANSPARENCY REGARDING THE ANNOUNCEMENT OF 17,000 CUTS
TO MILITARY HEALTH PROVIDERS**
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

**HOUSE ACTION: POLICY H-40.995 AMENDED AS FOLLOWS
IN LIEU OF RESOLUTION 246**

H-40.995, Graduate Medical Education in the Military

Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; ~~and~~ (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector; (3) urge the U.S. Department of Defense (DOD) to release any assessments or pertinent information used by the DOD to propose any reductions in the overall uniformed medical positions including but not limited to the number of medical provider billet cuts and their distribution amongst specialties and services; (4) advocate to the U.S. Congress to implement legislation mandating a study in the next National Defense Authorization Act to assess the impact of potential cuts on cost and healthcare quality outcomes for military service members, dependents, and retirees before drastic cuts are executed; and (5) oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for an equal number of civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States' physician shortage.

247. SENSIBLE APPROPRIATE USE CRITERIA IN MEDICARE
**Introduced by American Association of Neurological Surgeons, Congress of Neurological Surgeons,
American Academy of Family Physicians, American Society for Gastrointestinal Endoscopy,
American Society of Neuroimaging, American Urological Association, North American Spine Society,
Society for Cardiovascular Angiography and Interventions, American Academy of Orthopedic Surgeons**

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our AMA policy H-320.940, "Medicare's Appropriate Use Criteria Program," be amended by addition to read as follows:

Our AMA will continue to advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid Services can adequately address technical and workflow challenges with its implementation and any interaction between the Quality Payment Program (QPP) and the use of advanced diagnostic imaging appropriate use criteria, and support legislation that resolves technical and workflow challenges and/or removes barriers to modifying or aligning the AUC Program and the QPP.

301. AMERICAN BOARD OF MEDICAL SPECIALTIES ADVERTISING
Introduced by Virginia, American Association of Clinical Urologists, Louisiana, Mississippi

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association oppose the use of any physician fees, dues, etc., for any advertising by the American Board of Medical Specialties or any of their component boards to the general public.

302. CLIMATE CHANGE EDUCATION ACROSS THE MEDICAL EDUCATION CONTINUUM

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED

See Policy H-135.919

RESOLVED, That our American Medical Association (AMA) support teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; and be it further

RESOLVED, That our AMA make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and be it further

RESOLVED, That our AMA communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

**303. GRADUATE MEDICAL EDUCATION AND THE CORPORATE PRACTICE OF MEDICINE
Introduced by California**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-310.904

RESOLVED, That our American Medical Association recognize and support that the environment for education of residents and fellows must be free of the conflict of interest created between a training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; and be it further

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources; and be it further

RESOLVED< That our AMA study issues, including waiver of due process requirements, created by corporate-owned lay entity control of graduate medical education sites.

**304. TRACKING OUTCOMES AND SUPPORTING BEST PRACTICES OF
HEALTH CARE CAREER PIPELINE PROGRAMS
Introduced by California**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-200.985

RESOLVED, That our American Medical Association support the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and be it further

RESOLVED, That our AMA work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.

305. LACK OF SUPPORT FOR MAINTENANCE OF CERTIFICATION

Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-275.924 AND D-275.954 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association urge all American Board of Medical Specialties (ABMS) Boards to phase out the use of mandated, periodic, pass/fail, point-in-time examinations, and Quality Improvement/Practice Improvement components of the Maintenance of Certification process, and replace them with more longitudinal and formative assessment strategies that provide feedback for continuous learning and improvement and support a physician's commitment to ongoing professional development; and be it further

RESOLVED, That our AMA encourage all ABMS Boards to adopt and immediately begin the process of implementing the following recommendation from the Continuing Board Certification Vision For the Future Commission Final Report: "Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge."

306. INTEREST RATES AND MEDICAL EDUCATION

Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-305.925 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm Policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt."

307. MENTAL HEALTH SERVICES FOR MEDICAL STUDENTS

Introduced by New York

Resolution 307 was considered with Council on Medical Education Report 6.

See Council on Medical Education Report 6.

RESOLVED, That our American Medical Association recommend that the Association of American Medical Colleges strengthen their recommendations to all medical schools that medical schools provide confidential in-house mental health services at no cost to students, without billing health insurance, and that they set up programs to educate both students and staff about burnout, depression, and suicide.

308. MAINTENANCE OF CERTIFICATION MORATORIUM
Introduced by New York

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association call for an immediate end to the high stakes examination components as well as an end to the Quality Initiative (QI)/Practice Improvement (PI) components of Maintenance of Certification (MOC); and be it further

RESOLVED, That our AMA call for retention of continuing medical education (CME) and professionalism components (how physicians carry out their responsibilities safely and ethically) of MOC only; and be it further

RESOLVED, That our AMA petition the American Board of Medical Specialties for the restoration of certification status for all diplomates who have lost certification status solely because they have not complied with MOC requirements.

309. PROMOTING ADDICTION MEDICINE DURING A TIME OF CRISIS
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-120.960, H-310.906 AND D-120.985 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association endorse and support the incorporation of addiction medicine science into medical student education and residency training; and be it further

RESOLVED, That our AMA transmit this resolution to the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education (ACGME).

310. MENTAL HEALTH CARE FOR MEDICAL STUDENTS
Introduced by New York

Resolution 310 was considered with Council on Medical Education Report 6.
See Council on Medical Education Report 6.

RESOLVED, That our American Medical Association encourage all medical schools to assign a mental health provider to every incoming medical student; and be it further

RESOLVED, That our AMA encourage all medical schools to provide an easy way for medical students to select a different provider at any time; and be it further

RESOLVED, That our AMA encourage all medical schools to require each student's mental health professional or related staff to contact the student once per semester to ask if the student would like to meet with their mental health professional, unless the student already has an appointment to do so or has asked not to be contacted with regards to mental health appointments; and be it further

RESOLVED, That our AMA encourage all medical schools to provide an easy process for students to initiate treatment with school mental health professionals at no cost to the student or professional from the mental health community at affordable cost to the student, and without undue bureaucratic burden.

**311. GRANDFATHERING QUALIFIED APPLICANTS PRACTICING IN U.S.
INSTITUTIONS WITH RESTRICTED MEDICAL LICENSURE
Introduced by International Medical Graduates Section**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards, the Organized Medical Staff Section and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. health care system.

**312. UNMATCHED MEDICAL GRADUATES TO ADDRESS THE SHORTAGE
OF PRIMARY CARE PHYSICIANS
Introduced by International Medical Graduates Section**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association advocate for the state medical boards to accept medical graduates who have passed USMLE Steps 1 and 2 as their criterion for limited license, thus using the existing physician workforce of trained and certified physicians in the primary care field and allowing them to get some credit towards their residency training as is being contemplated in Utah; and be it further

RESOLVED, That our AMA work with regulatory, licensing, medical, and educational entities dealing with physician workforce issues: the American Board of Medical Specialties, the Association of American Medical Colleges (AAMC), the Association for Hospital Medical Education, Accreditation Council for Graduate Medical Education (ACGME), the Federation of State Medical Boards, and the National Medical Association work together to integrate unmatched physicians in the primary care workforce in order to address the projected physician shortage.

**313. CLINICAL APPLICATIONS OF PATHOLOGY AND LABORATORY MEDICINE
FOR MEDICAL STUDENTS, RESIDENTS AND FELLOWS
Introduced by Resident and Fellow Section**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-295.930

RESOLVED, That our American Medical Association study current practices within medical education regarding the clinical use of pathology and laboratory medicine information to identify potential gaps in training in the principles of decision making and the utilization of quantitative evidence.

**314. EVALUATION OF CHANGES TO RESIDENCY AND FELLOWSHIP
APPLICATION AND MATCHING PROCESSES
Introduced by Resident and Fellow Section**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-310.998

RESOLVED, That our American Medical Association oppose changes to residency and fellowship application requirements unless (a) those changes have been evaluated by working groups which have students and residents as representatives; (b) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate; (c) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds; and (4) the costs to medical students and residents are mitigated: and be it further

RESOLVED, That our AMA continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

**315. SCHOLARLY ACTIVITY BY RESIDENT AND FELLOW PHYSICIANS
Introduced by Resident and Fellow Section**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-310.905

RESOLVED, That our American Medical Association a) define resident and fellow scholarly activity as any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity, and b) encourage partner organizations to utilize the inclusion of this definition to ensure that residents and fellows are able to fulfill scholarly activity requirements.

**316. MEDICAL STUDENT DEBT
Introduced by Senior Physicians Section**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-305.925

RESOLVED, That our American Medical Association formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

**317. A STUDY TO EVALUATE BARRIERS TO MEDICAL EDUCATION
FOR TRAINEES WITH DISABILITIES
Introduced by Resident and Fellow Section**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-295.929

RESOLVED, That our American Medical Association work with relevant stakeholders to study available data on medical trainees with disabilities and consider revision of technical standards for medical education programs; and be it further

RESOLVED, That our AMA work with relevant stakeholders to study available data on medical graduates with disabilities and challenges to employment after training.

**318. RURAL HEALTH PHYSICIAN WORKFORCE DISPARITIES
Introduced by Iowa**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-465.988

RESOLVED, That our American Medical Association undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.

**319. ADDING PIPELINE PROGRAM PARTICIPATION QUESTIONS
TO MEDICAL SCHOOL APPLICATIONS
Introduced by Minority Affairs Section**

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-200.985

RESOLVED, That our American Medical Association work with the Association of American Medical Colleges (AAMC) and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

**320. OPIOID EDUCATION IN MEDICAL SCHOOLS
Introduced by Michigan**

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES H-120.960 AND D-120.985 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with the Liaison Committee on Medical Education to include formalized opioid and related substance use disorder training using an evidence-based multidisciplinary approach in the curriculum of accredited medical schools.

**321. PHYSICIAN HEALTH PROGRAM ACCOUNTABILITY, CONSISTENCY, AND EXCELLENCE
IN PROVISION OF SERVICE TO THE MEDICAL PROFESSION**

Introduced by Michigan, North Carolina

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED

See Policy D-405.990

RESOLVED, That our American Medical Association amend policy D-405.990, “Educating Physicians About Physician Health Programs,” by addition and deletion to read as follows:

D-405.990, Educating Physicians About Physician Health Programs and Advocating for Standards

1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; ~~and~~ 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training; and 5) Our AMA will continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; 6) Our AMA will continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.

**322. SUPPORT FOR THE STUDY OF THE TIMING AND CAUSES FOR LEAVE OF ABSENCE
AND WITHDRAWAL FROM UNITED STATES ALLOPATHIC AND OSTEOPATHIC
MEDICAL UNDERGRADUATE AND GRADUATE EDUCATION PROGRAMS**

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS

TITLE CHANGED

See Policy H-295.856

RESOLVED, That our American Medical Association support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved; and be it further

RESOLVED, That our AMA encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved.

**323. IMPROVING ACCESS TO CARE IN MEDICALLY UNDERSERVED AREAS THROUGH
PROJECT ECHO AND THE CHILD PSYCHIATRY ACCESS PROJECT MODEL**
Introduced by Texas

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED

See Policy H-200.954

RESOLVED, That our American Medical Association promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; and be it further

RESOLVED, That our AMA work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and be it further

RESOLVED, That our AMA monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

**324. RESIDENCY AND FELLOWSHIP PROGRAM DIRECTOR, ASSISTANT/ASSOCIATE PROGRAM
DIRECTOR, AND CORE FACULTY PROTECTED TIME AND SALARY REIMBURSEMENT**
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED

See Policy H-310.912

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or “protected time” for resident and fellow education by “core faculty,” program directors, and assistant/associate program directors.

401. SUPPORT PREGNANCY INTENTION SCREENING
Introduced by Oregon

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED

See Policy H-425.976

RESOLVED, That our American Medical Association support the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.

402. BULLYING IN THE PRACTICE OF MEDICINE
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association help establish a clear definition of professional bullying, establish prevalence and impact of professional bullying, and establish guidelines for prevention of professional bullying with a report back at the 2020 Annual Meeting.

403. WHITE HOUSE INITIATIVE ON ASIAN AMERICANS AND PACIFIC ISLANDERS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED

See Policy H-350.954

RESOLVED, That our American Medical Association advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; and be it further

RESOLVED, That our AMA support the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; and be it further

RESOLVED, That our AMA support the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and be it further

RESOLVED, That our AMA report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

404. SHADE STRUCTURES IN PUBLIC AND PRIVATE PLANNING AND ZONING MATTERS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont,
American Academy of Dermatology, Society for Investigative Dermatology,
American Society of Dermatopathology, American Society for Dermatologic Surgery Association

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-440.839

RESOLVED, That our American Medical Association support sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical importance of sun protection as a public health measure.

405. FIREARM VIOLENCE PREVENTION: SAFETY FEATURES
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-145.997

RESOLVED, That our American Medical Association advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-law enforcement use within the U.S., with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

406. REDUCTION IN CONSUMPTION OF PROCESSED MEATS
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-150.922

That our AMA support: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives.

**407. EVALUATING AUTONOMOUS VEHICLES AS A MEANS TO REDUCE
MOTOR VEHICLE ACCIDENTS**
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy D-15.992

RESOLVED, That our American Medical Association monitor the development of autonomous vehicles, with particular focus on the technology's impact on motor vehicle related injury and death; and be it further

RESOLVED, That our AMA promote driver, pedestrian, and general street and traffic safety as key priorities in the development of autonomous vehicles.

408. BANNING EDIBLE CANNABIS PRODUCTS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association adopt policy supporting a total ban on recreational edible cannabis products; and be it further

RESOLVED, That our AMA support or cause to be introduced legislation to ban all recreational edible cannabis products.

409. ADDRESSING THE VAPING CRISIS
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association advocate to the Food and Drug Administration that vaping devices should be available only by prescription for smokers who are trying to quit smoking.

410. REDUCING HEALTH DISPARITIES THROUGH EDUCATION
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
POLICY H-60.917 REAFFIRMED
See Policy H-60.917

RESOLVED, That our American Medical Association work with the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; and be it further

RESOLVED, That our AMA work with the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.

411. AMA TO ANALYZE BENEFITS / HARMS OF LEGALIZATION OF MARIJUANA
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association review pertinent data from those states that have legalized marijuana.

412. REGULATING LIQUID NICOTINE AND E-CIGARETTES
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY H-495.988 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek legislation or regulations that limit higher concentration nicotine salts (greater than 10mg) in nicotine vaping pods and restrict bulk sale of vaping products and associated paraphernalia.

413. END THE EPIDEMIC OF HIV NATIONALLY
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-20.896

RESOLVED, That our American Medical Association supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (1) diagnosing individuals with HIV infection as early as possible, (2) treating HIV infection to achieve sustained viral suppression, (3) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (4) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.

414. PATIENT MEDICAL MARIJUANA USE IN HOSPITALS
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association offer guidance to medical staffs regarding patient use of non-US Food and Drug Administration approved medical marijuana and cannabinoids on hospital property, including product use, storage in patient rooms, nursing areas and/or pharmacy, with report back to the House of Delegates at the 2019 Interim Meeting.

415. DISTRACTED DRIVER LEGISLATION
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-15.993

RESOLVED, That our American Medical Association actively lobby for legislation to decrease distracted driving injuries and fatalities by banning the use of electronic communication such as texting, taking photos or video and posting on social media while operating a motor vehicle.

416. NON-MEDICAL EXEMPTIONS FROM IMMUNIZATIONS
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-440.970

RESOLVED, That our American Medical Association actively advocate for legislation, regulations, programs, and policies that incentivize states to eliminate non-medical exemptions from mandated pediatric immunizations.

417. IMPROVED HEALTH IN CORRECTIONAL FACILITIES THROUGH HYGIENE AND HEALTH EDUCATIONAL PROGRAMMING FOR INMATES AND PRISON STAFF
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-430.986

RESOLVED, That our American Medical Association collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.

418. ELIMINATING THE DEATH TOLL FROM COMBUSTIBLE CIGARETTES
Introduced by Washington

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association study and report on the conditions under which our country could successfully eliminate the manufacture, distribution, and sale of combustible cigarettes and other combustible tobacco products at the earliest feasible date.

419. UNIVERSAL ACCESS FOR ESSENTIAL PUBLIC HEALTH SERVICES

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
See Policies H-440.912 and D-440.924

RESOLVED that our AMA: (1) supports updating The Core Public Health Functions Steering Committee's "The 10 Essential Public Health Services" to bring them in line with current and future public health practice; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system; and (5) reaffirms existing Policy H-440.912.

420. COORDINATING CORRECTIONAL AND COMMUNITY HEALTHCARE
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-430.986

RESOLVED, That our American Medical Association support linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse

disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and be it further

RESOLVED, That our AMA support the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

421. CONTRACEPTION FOR INCARCERATED WOMEN

Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-430.997

That our AMA support an incarcerated person's right to (1) accessible, comprehensive, evidence-based contraception education, (2) access to reversible contraceptive methods, and (3) autonomy over the decision-making process without coercion.

422. PROMOTING NUTRITION EDUCATION AMONG HEALTHCARE PROVIDERS

Introduced by Resident and Fellow Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-150.953 AND H-150.995 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That American Medical Association Policy H-150.995, "Basic Courses in Nutrition," be reaffirmed; and be it further

RESOLVED, That AMA Policy H-150.953, "Obesity as a Major Public Health Problem," be reaffirmed.

423. MEDICALLY APPROPRIATE CARE FOR ASYLUM SEEKERS

Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS TITLE CHANGED

See Policy H-350.957

RESOLVED, That our American Medical Association call for asylum seekers to receive all medically-appropriate care, including vaccinations, in a patient-centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

**424. PHYSICIAN INVOLVEMENT IN STATE REGULATIONS OF MOTOR VEHICLE OPERATION
AND/OR FIREARM USE BY INDIVIDUALS WITH COGNITIVE DEFICITS DUE
TO TRAUMATIC BRAIN INJURY**

Introduced by American Academy of Physical Medicine and Rehabilitation

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association reaffirm current AMA Policy H 145.999, “Gun Regulation,” stating it supports stricter enforcement of current federal and state gun legislation; and be it further

RESOLVED, That our AMA advocate for physician-led committees in each state to give further recommendations to the state regarding driving and/or gun use by individuals who are cognitively impaired and/or a danger to themselves or others.

**425. DISTRACTED DRIVER EDUCATION AND ADVOCACY
Introduced by Georgia**

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED

See Policy H-15.952

RESOLVED, That our American Medical Association make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with the Centers for Disease Control and other interested stakeholders; and be it further

RESOLVED, That our AMA explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting.

**426. HEALTH CARE ACCREDITATION OF CORRECTIONAL, DETENTION
AND JUVENILE FACILITIES
Introduced by Minority Affairs Section, American Association of Public Health Physicians**

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-430.997

RESOLVED, That our American Medical Association work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities; and be it further

RESOLVED, That our AMA advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and support funding for correctional facilities to assist in this effort.

**427. UTILITY OF AUTONOMOUS VEHICLES FOR INDIVIDUALS WHO ARE VISUALLY
IMPAIRED OR DEVELOPMENTALLY DISABLED**
Introduced by Michigan

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED

See Policy D-15-992

RESOLVED, That our American Medical Association work with the National Transportation Safety Board to support physician input on research into the capability of autonomous or “self-driving” vehicles to enable individuals who are visually impaired or developmentally disabled to benefit from autonomous vehicle technology.

428. DANGERS OF VAPING

Reference committee hearing: see report of Reference Committee D.

**HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
POLICY H-495.989 AMENDED AS FOLLOWS
IN LIEU OF RESOLUTION 428**

See Policies H-495.972 and H-495.989

RESOLVED, That our American Medical Association support legislation and associated initiatives and work in coordination with the Surgeon General to prevent ENDS from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of ENDS, and combustible and emerging tobacco products.

H-495.989, Tobacco Product Labeling

Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: “Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;” ~~and~~ (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.

Resolution 429 was reassigned as Resolution 531.

430. COMPASSIONATE RELEASE FOR INCARCERATED PATIENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders to draft model legislation that establishes clear, evidence-based eligibility criteria for timely compassionate release; and be it further

RESOLVED, That our AMA promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

431. ELIMINATING RECOMMENDATIONS TO RESTRICT DIETARY CHOLESTEROL AND FAT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association amend Policy H-150.944, “Combating Obesity and Health Disparities,” by addition and deletion to read as follows:

H-150.944, Combating Obesity and Health Disparities

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of ~~foods and beverages low in fat, added sugars, and cholesterol,~~ healthful foods and beverages.

432. DECRIMINALIZATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV)
STATUS NON-DISCLOSURE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-20.914

RESOLVED, That our American Medical Association advocate for repeal of legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV; and be it further

RESOLVED, That our AMA work with other stakeholders to develop a program whose primary goal is to destigmatize HIV infection through educating the public, physicians, and other health care professionals on current medical advances in HIV treatment that minimize the risk of transmission due to viral load suppression and the availability of PrEP.

433. TRANSFORMATION OF RURAL COMMUNITY PUBLIC HEALTH SYSTEMS**Introduced by Nebraska, West Virginia***Reference committee hearing: see report of Reference Committee D.***HOUSE ACTION: ADOPTED AS FOLLOWS***See Policy H-465.994*

RESOLVED, That our American Medical Association work with other entities and organizations interested in public health to:

- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health;
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities;
- Study efforts to optimize rural public health.

434. CHANGE IN MARIJUANA CLASSIFICATION TO ALLOW RESEARCH**Introduced by New Jersey***Reference committee hearing: see report of Reference Committee D.***HOUSE ACTION: POLICY H-95.952 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association petition the US Food and Drug Administration / US Drug Enforcement Administration to change the schedule classification of marijuana so that it can be subjected to appropriate research.

501. USP 800**Introduced by Virginia; American College of Allergy, Asthma and Immunology; Kansas; South Carolina; Louisiana; Maryland***Reference committee hearing: see report of Reference Committee E.***HOUSE ACTION: ADOPTED AS FOLLOWS***See Policy H-120.930*

RESOLVED, That our AMA continue its compounding working group consisting of national specialty organizations, state medical societies, relevant agencies, and other appropriate stakeholders to advocate for appropriate application of standards and to monitor policy impacting physicians.

502. DESTIGMATIZING THE LANGUAGE OF ADDICTION**Introduced by Young Physicians Section***Reference committee hearing: see report of Reference Committee E.***HOUSE ACTION: ADOPTED***See Policies H-95.917 and D-95.966*

RESOLVED, That our American Medical Association use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports,

and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty; and be it further

RESOLVED, That our AMA and relevant stakeholders create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities.

503. CHILDREN OF INCARCERATED PARENTS

Reference committee hearing: see report of Reference Committee E.

**HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION 503 ADOPTED
IN LIEU OF RESOLUTIONS 503 AND 531**
See Policy H-60.903

RESOLVED, That our American Medical Association support comprehensive evidence-based care, legislation, and initiatives that address the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who are at risk.

504. ADVERSE CHILDHOOD EXPERIENCES AND TRAUMA-INFORMED CARE

Reference committee hearing: see report of Reference Committee E.

**HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION 504 ADOPTED
IN LIEU OF RESOLUTIONS 504 AND 526**
See Policy H-515.952

RESOLVED, That our American Medical Association recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization; and be it further

RESOLVED, That our American Medical Association supports:

- evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
- evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
- efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
- efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
- funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.

505. GLYPHOSATE STUDIES Introduced by California

Reference committee hearing: see report of Reference Committee E.

**HOUSE ACTION: POLICIES H-135.942 AND D-135.997 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for a reduction in the use of glyphosate-based pesticides (the primary chemical in the herbicide branded Roundup), encourage the evaluation of alternatives, and support additional research to determine the long-term effects and association between glyphosate and disease.

**506. CLARIFY ADVERTISING AND CONTENTS OF HERBAL REMEDIES
AND DIETARY SUPPLEMENTS
Introduced by Illinois**

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES H-115.988, H-150.946, H-150.954 AND D-150.991 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with the National Center for Complementary and Integrative Health (NCCIH), the federal agency responsible for oversight of herbal remedies and dietary supplements, to institute stricter guidelines for advertising and labeling of these products so that consumers will be informed of what they are purchasing; and be it further

RESOLVED, that our AMA support a licensing body through legislation for manufacturers of dietary supplements and herbal remedies, with the requirement that those manufacturers must supply proof that their products have health benefits; and be it further

RESOLVED, That our AMA urge that the increased cost of a stricter NCCIH program on dietary supplements and herbal remedies be paid for by the manufacturers who produce them.

**507. REMOVING ETHYLENE OXIDE AS A MEDICAL STERILANT FROM HEALTHCARE
Introduced by Illinois**

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association adopt as policy and urge, as appropriate, the prevention of ethylene oxide emissions and substitution of ethylene oxide with less toxic sterilization alternatives that are currently available, including hydrogen peroxide, steam, and other safer alternatives, which do not release carcinogens into the workplace or community air and allow no residual exposures to the patient; and be it further

RESOLVED, That our AMA adopt as policy and urge that when health care facilities are evaluating surgical and medical devices that require sterilization, in addition to effectiveness of the device for best patient outcomes, that facilities also be required to prioritize the modes of sterilization for the highest degree of worker and environmental safety.

**508. CONCOMITANT USE OF BENZODIAZEPINES AND OPIOIDS
Introduced by New York**

Reference committee hearing: see report of Reference Committee E.

**HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-100.966**

RESOLVED, That our American Medical Association raise the awareness of physicians and patients regarding the increased use of illicit benzodiazepine/opioid combinations leading to addiction and overdose death; and be it further

RESOLVED, That our AMA warn physicians and patients about the risks associated with concomitant use of benzodiazepines and opioids.

509. ADDRESSING DEPRESSION TO PREVENT SUICIDE EPIDEMIC
Introduced by International Medical Graduates Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-345.984 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association collaborate with the Centers for Disease Control and Prevention (CDC), the National Institute of Health (NIH) and other stakeholders to increase public awareness about symptoms, early signs, preventive and readily available therapeutic measures including antidepressants to address depression and suicide; and be it further

RESOLVED, That our AMA work with the CDC, the NIH and encourage other specialty and state medical societies to work with their members to address the epidemic of depression and anxiety disorder and help to prevent death by suicide by promoting services to screen, diagnose and treat depression.

510. THE INTRACRANIAL HEMORRHAGE ANTICOAGULATION REVERSAL (ICHAR) INITIATIVE
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-130.934

RESOLVED, That our American Medical Association support initiatives to improve education, and reduce barriers (including lack of resources) for the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening conditions.

511. MANDATING CRITICAL CONGENITAL HEART DEFECT SCREENING IN NEWBORNS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy H-245.973

RESOLVED, That our American Medical Association support screening for critical congenital heart defects for newborns following delivery prior to hospital discharge.

512. DISCLOSURE OF RISK TO FERTILITY WITH GONADOTOXIC TREATMENT
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-425.967

RESOLVED, That our American Medical Association supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and be it further

RESOLVED, That our AMA support ongoing education for providers who counsel patients who may benefit from fertility preservation.

**513. DETERMINING WHY INFERTILITY RATES DIFFER BETWEEN MILITARY
AND CIVILIAN WOMEN****Introduced by Women Physicians Section***Reference committee hearing: see report of Reference Committee E.***HOUSE ACTION: ADOPTED AS FOLLOWS***See Policy H-510.984*

RESOLVED, That our American Medical Association support additional research to better understand whether higher rates of infertility in service women may be linked to military service, and which approaches might reduce the burden of infertility among service women.

514. PAIN MANAGEMENT FOLLOWING CAESARIAN BIRTH**Introduced by American Medical Women's Association***Reference committee hearing: see report of Reference Committee E.***HOUSE ACTION: ADOPTED AS FOLLOWS****TITLE CHANGED****POLICY H-420.962 REAFFIRMED***See Policies H-420.962 and D-420.990*

RESOLVED, That our American Medical Association support a stepwise, multi-modal approach to analgesia management (which may include nonpharmacologic and pharmacologic therapies including opioids) using a shared decision-making approach to minimize pain and improve function after caesarian birth with the goal of transitioning to other methods of pain control for long term; and be it further

RESOLVED, That our AMA work with hospitals and relevant stakeholders to support the adoption of enhanced recovery after surgery protocol for caesarian section to optimize recovery and improve function while decreasing use of opioid medications for pain; and be it further

RESOLVED, that our AMA support counseling of women who are prescribed opioid analgesics following caesarean birth about the risk of central nervous system depression in the woman and the breastfed infant.

515. EDUCATION ON SEX-BASED RESPONSE TO OPIOIDS**Introduced by American Medical Women's Association***Reference committee hearing: see report of Reference Committee E.***HOUSE ACTION: ADOPTED AS FOLLOWS****TITLE CHANGED***See Policy D-525.993*

RESOLVED, That our American Medical Association include educational materials for physicians regarding sex-based differences in their resources related to the opioid epidemic. These sex-based differences include the perception of pain, the impact of co-morbid conditions, response to opioids, risks for opioid use disorder, issues with access, and outcomes of addiction treatment programs among women.

516. ALCOHOL CONSUMPTION AND HEALTH
Introduced by American Society of Clinical Oncology

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-30.934

RESOLVED, That our American Medical Association recognize that alcohol consumption at any level, not just heavy alcohol use or addictive alcohol use, is a modifiable risk factor for cancer.

517. COMPOUNDING

**Introduced by American Academy of Dermatology, American Academy of Cosmetic Surgery,
American College of Mohs Surgery, American Society for Dermatologic Surgery Association,
Society for Investigative Dermatology, American Society of Dermatopathology, Missouri, Florida,
American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society for Aesthetic Plastic
Surgery, American Academy of Facial Plastic and Reconstructive Surgery, Wisconsin, South Carolina,
American Vein and Lymphatic Society, New York, Utah, International Society of Hair Restoration Surgery;
American College of Allergy, Asthma and Immunology; American Society of Plastic Surgeons**

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association provide a 50-state analysis of state law requirements governing in-office preparation of medications in physicians' offices, including which states have adopted USP Chapter 797 and how compounding is defined by state law; and be it further

RESOLVED, That our AMA advocate that the preparation of medications in physicians' offices is the practice of medicine and should be defined by and remain under the purview of state medical licensing boards rather than state pharmacy boards or other state regulatory bodies; and be it further

RESOLVED, That our AMA work with medical specialty societies to preserve a physician's ability to prepare medications in physicians' offices and be able to do so without being subject to unreasonable and burdensome equipment and process requirements.

NOTE: Prior to referral, the second resolve had been amended by substitution as rendered above.

518. CHEMICAL VARIABILITY IN PHARMACEUTICAL PRODUCTS
Introduced by American College of Cardiology

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association do a study and report back by the 2019 Interim Meeting regarding the pharmaceutical variability, both in active pharmaceutical ingredient and dissolution, the impact on patient care and make recommendations for action from their report findings; and be it further

RESOLVED, That our AMA advocate for legislation requiring independent testing and verification of the chemical content of batches of pharmaceuticals; and be it further

RESOLVED, That our AMA advocate for the logging of batches at the patient level, so the batches can be traced and connected to patient outcomes or adverse events.

**519. CHILDCARE AVAILABILITY FOR PERSONS RECEIVING SUBSTANCE
USE DISORDER TREATMENT**
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED

See Policy H-95.916

RESOLVED, That our American Medical Association support the implementation of childcare resources in existing substance use treatment facilities and acknowledge childcare infrastructure and support as a major priority in the development of new substance use programs.

520. SUBSTANCE USE DURING PREGNANCY
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS

POLICY H-95.985 REAFFIRMED

See Policies H-95.985 and H-420.950

RESOLVED, That our American Medical Association amend Policy H-420.950, “Substance Use Disorders During Pregnancy,” by addition and deletion as follows:

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse; ~~and~~ (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual’s family structure, (b) the patient’s treatment status, and (c) current impairment status when substance use is suspected.

521. PUT OVER-THE-COUNTER INHALED EPINEPHRINE BEHIND PHARMACY COUNTER
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-115.972 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with national pharmacy chains to move inhaled epinephrine (Primatene Mist HFA) behind the counter.

522. IMPROVED DEFERRAL PERIODS FOR BLOOD DONORS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-50.973

RESOLVED, That our American Medical Association amend AMA Policy H-50.973, “Blood Donor Deferral Criteria,” by addition and deletion to read as follows:

Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence ~~the scientific literature;~~ and (3) supports a blood donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood donation.

523. AVAILABILITY AND USE OF LOW STARTING OPIOID DOSES
Introduced by Michigan

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES, D-120.947, D-120.971, D-120.976 AND D-160.981 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association reaffirm AMA Policies D-160.981, “Promotion of Better Pain Care,” D 120.947, “A More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief,” D-120.976, “Pain Management,” and D-120.971, “Promoting Pain Relief and Preventing Abuse of Controlled Substances,” to ensure the dissemination of educational materials for physicians on options for prescribing the lowest effective dosage, such as hydrocodone 2.5 mg or oxycodone 2.5 mg with acetaminophen, for patients who need an initial prescription for an oral narcotic and work with pharmacies and other relevant stakeholders to ensure lower dosage options are stocked and available at prices that do not exceed that of the same narcotic at a higher dosage.

524. AVAILABILITY OF NALOXONE BOXES
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy H-95.932

RESOLVED, That our American Medical Association support the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription; and be it further

RESOLVED, That our AMA amend Policy H-95.932, “Increasing Availability of Naloxone,” by addition and deletion as follows:

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. 2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone. 3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients. 4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing. 5. Our AMA

supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law. 6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively. 7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration. 8. Our AMA ~~urges the Food and Drug Administration to study the practicality and utility of~~ supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.

**525. SUPPORT FOR ROOMING-IN OF NEONATAL ABSTINENCE SYNDROME
PATIENTS WITH THEIR PARENTS
Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-420.949

RESOLVED, That our American Medical Association supports keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient's health and safety permits, and as supported by validated risk stratification tools for rooming-in programs; and be it further

RESOLVED, That our AMA support the education of physicians about rooming-in patients with neonatal abstinence syndrome.

**526. TRAUMA-INFORMED CARE RESOURCES AND SETTINGS
Introduced by Medical Student Section**

Resolution 526 was considered with Resolution 504. See Resolution 504.

RESOLVED, That our American Medical Association recognize trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization; and be it further

RESOLVED, That our AMA support trauma-informed care in all settings, including but not limited to clinics, hospitals, and schools, by directing physicians and medical students to evidenced-based resources.

**527. INCREASING THE AVAILABILITY OF BLEEDING CONTROL SUPPLIES
Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy H-130.935

RESOLVED, That American Medical Association Policy H-130.935, "Support for Hemorrhage Control Training," be amended by addition to read as follows:

H-130.935, Support for Hemorrhage Control Training

1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.

2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
3. Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings.

**528. DEVELOPING DIAGNOSTIC CRITERIA AND EVIDENCE-BASED TREATMENT OPTIONS
FOR PROBLEMATIC PORNOGRAPHY VIEWING
Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED

See Policy H-60.990

RESOLVED, That our American Medical Association support research on problematic pornography use, including its physiological and environmental drivers, appropriate diagnostic criteria, effective treatment options, and relationships to erectile dysfunction and domestic violence.

**529. ADVERSE IMPACTS OF DELAYING THE IMPLEMENTATION OF
PUBLIC HEALTH REGULATIONS
Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-440.925

RESOLVED, That our American Medical Association monitor and evaluate regulation delays that impact public health, and advocate as appropriate to decrease regulatory delays.

**530. IMPLEMENTING NALOXONE TRAINING INTO THE BASIC LIFE SUPPORT (BLS)
CERTIFICATION PROGRAM
Introduced by New Jersey**

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-130.961

RESOLVED, That our American Medical Association collaborate with the American Heart Association and other interested parties to include naloxone use in training in BLS instruction.

**531. SUPPORT FOR CHILDREN OF INCARCERATED PARENTS
Introduced by Medical Student Section**

Resolution 531 was considered with Resolution 503. See Resolution 503.

RESOLVED, That our American Medical Association support legislation and initiatives that provide resources and support for children of incarcerated parents.

532. DISPELLING MYTHS OF BYSTANDER OPIOID OVERDOSE
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED

See Policy D-95.965

RESOLVED, That our American Medical Association work with appropriate stakeholders to develop and disseminate educational materials aimed at dispelling the fear of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives; and be it further

RESOLVED, That our AMA work with appropriate stakeholders to identify those professions, such as first responders, most impacted by opioid overdose deaths in order to provide targeted education to dispel the myth of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives.

601. AMA POLICY STATEMENT WITH EDITORIALS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association include a policy statement after all editorials in which policy has been established to clarify our position.

602. EXPECTATIONS FOR BEHAVIOR AT HOUSE OF DELEGATES MEETINGS
Introduced by Susan R. Bailey, MD, Delegate and Bruce A. Scott, MD, Delegate

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED

See Policy G-600.032

RESOLVED, That every AMA HOD delegate and alternate delegate shall, as a condition to receiving their credentials for any AMA HOD meeting, acknowledge and accept during the AMA HOD meeting registration process (i) AMA policies concerning conduct at AMA HOD meetings and (ii) applicable adjudication and disciplinary processes for violations of such policies; and be it further

RESOLVED, That any AMA HOD delegate or alternate delegate who knowingly fails to acknowledge and accept during the AMA HOD meeting registration process (i) AMA policies concerning conduct at AMA HOD meetings and (ii) applicable adjudication and disciplinary processes for violations of such policies shall not be credentialed as a delegate or alternate delegate at that meeting.

603. CREATION OF AN AMA ELECTION REFORM COMMITTEE

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION 603 ADOPTED
IN LIEU OF RESOLUTIONS 603 AND 611**
See Policy G-610.031

RESOLVED, That our AMA create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.

604. ENGAGE AND COLLABORATE WITH THE JOINT COMMISSION
Introduced by Illinois

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association study and report back on any potential impact, influence, or conflicts of interest related to unrestricted grants from pharmaceutical and medical device manufacturers on the development of Joint Commission accreditation standards (especially those that relate to medical prescribing, procedures, and clinical care by licensed physicians).

605. STATE SOCIETIES AND THE AMA LITIGATION CENTER
Introduced by New York

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED
See Policy G-620.020

RESOLVED, That when seeking a state medical society's support of an amicus brief on a legal matter, especially one pertaining to an issue in that state, the American Medical Association Litigation Center consider the state medical society's point of view in developing the argument, and maintain full disclosure during the drafting of the amicus or any change in strategy.

606. INVESTIGATION INTO RESIDENTS, FELLOWS, AND PHYSICIAN UNIONS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-383.977

RESOLVED, That our American Medical Association study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment.

607. RE-ESTABLISHMENT OF NATIONAL GUIDELINE CLEARINGHOUSE**Introduced by American Society of Clinical Oncology***Reference committee hearing: see report of Reference Committee F.***HOUSE ACTION: ADOPTED***See Policy D-410.991*

RESOLVED, That our American Medical Association reaffirm Policy H-410.965, “Clinical Practice Guidelines, Performance Measures, and Outcomes Research Activities”; and be it further

RESOLVED, That our AMA research possible and existing alternatives for the functions of the National Guidelines Clearinghouse with a report back to the House of Delegates.

608. FINANCIAL PROTECTIONS FOR DOCTORS IN TRAINING**Introduced by Resident and Fellow Section***Reference committee hearing: see report of Reference Committee F.***HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association support retirement plans for all residents and fellows, which includes retirement plan matching in order to further secure the financial stability of physicians and increase financial literacy during training; and be it further

RESOLVED, That our AMA support that all programs provide financial advising to resident and fellows.

609. UPDATE TO AMA POLICY H-525.998, “WOMEN IN ORGANIZED MEDICINE”**Introduced by Women Physicians Section***Reference committee hearing: see report of Reference Committee F.***HOUSE ACTION: ADOPTED***See Policy H-525.998*

RESOLVED, That our AMA amend AMA Policy H-525.998, “Women in Organized Medicine,” by addition and deletion to read as follows:

Our AMA:

- (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession;
- (2) supports the concept of increased tax benefits for working parents;
- (3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings; and
- (4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs; ~~and~~
- (5) ~~supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site.~~

610. MITIGATING GENDER BIAS IN MEDICAL RESEARCH
Introduced by Illinois

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED

See Policy H-460.891

RESOLVED, That our American Medical Association advocate for the establishment of best practices that remove any gender bias from the review and adjudication of grant applications and submissions for publication in peer-reviewed journals, including removing names and gender identity from the applications or submissions during the review process.

611. ELECTION REFORM
**Introduced by Radiological Society of North America, American Society for Radiation Oncology,
American Institute of Ultrasound in Medicine, Iowa**

Resolution 611 was considered with Resolution 603. See Resolution 603.

RESOLVED, That our American Medical Association create a speaker-appointed task force to re-examine election rules and logistics including regarding social media, emails, mailers, receptions and parties, ability of candidates from smaller delegations to compete, balloting electronically, and timing within the meeting, and report back recommendations regarding election processes and procedures to accommodate improvements to allow delegates to focus their efforts and time on policy-making; and be it further

RESOLVED, That our AMA's speaker-appointed task force consideration should include addressing (favorably or unfavorably) the following ideas:

- a) Elections being held on the Sunday morning of the annual and interim meetings of the House of Delegates.
- b) Coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously.
- c) Separating the logistical election process based on the office (e.g. larger interview session for council candidates, more granular process for other offices)
- d) An easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail.
- e) Electronic balloting potentially using delegates' personal devices as an option for initial elections and runoffs in order to facilitate timely results and minimal interruptions to the business.
- f) Seeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process.
- g) Address the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g. vote trading, block voting, etc.); and be it further

RESOLVED, That the task force report back to the HOD at the 2019 Interim meeting.

612. REQUEST TO AMA FOR TRAINING IN HEALTH POLICY AND HEALTH LAW
Introduced by New Mexico

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association offer its members training in health policy and health law, and develop a fellowship in health policy and health law.

613. LANGUAGE PROFICIENCY DATA OF PHYSICIANS IN THE AMA MASTERFILE
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association initiate collection of self-reported physician language proficiency data in the Masterfile by asking physicians with the validated six-point adapted ILR-scale for physicians to indicate their level of proficiency for each language besides English in the healthcare settings.

614. RACIAL AND ETHNIC IDENTITY DEMOGRAPHIC COLLECTION BY THE AMA
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-350.982

RESOLVED, That our American Medical Association develop a plan with input from the Minority Affairs Section and the Chief Health Equity Officer to improve consistency and reliability in the collection of racial and ethnic minority demographic information for physicians and medical students.

**615. IMPLEMENTING AMA CLIMATE CHANGE PRINCIPLES THROUGH JAMA PAPER
CONSUMPTION REDUCTION AND GREEN HEALTHCARE LEADERSHIP**
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association change existing automatic paper *JAMA* subscriptions to opt-in paper subscriptions by the year 2020, while preserving the option to receive paper *JAMA*, in order to support broader climate change efforts.

616. TIME'S UP HEALTHCARE
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED
See Policy D-65.988

RESOLVED, That our American Medical Association evaluate TIME'S UP Healthcare program and consider participation as a TIME'S UP partner in support of our mutual objectives to eliminate harassment and discrimination in medicine with report back at the 2019 Interim Meeting.

617. ADVOCACY FOR PHYSICIANS WITH DISABILITIES**Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont***Reference committee hearing: see report of Reference Committee F.***HOUSE ACTION: ADOPTED AS FOLLOWS****TITLE CHANGED***See Policy D-90.991*

RESOLVED, That our American Medical Association study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to:

1. Enhancing representation of physicians with disabilities within the AMA.
2. Examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA; and be it further

RESOLVED, That our AMA identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration; and be it further

RESOLVED, That our AMA support physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.

618. STAKEHOLDER INPUT TO REPORTS OF THE HOUSE OF DELEGATES**Introduced by Integrated Physician Practice Section***Reference committee hearing: see report of Reference Committee F.***HOUSE ACTION: ADOPTED AS FOLLOWS***See Policy G-600.071*

RESOLVED, That our American Medical Association provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

701. CODING FOR PRIOR AUTHORIZATION OBSTACLES**Introduced by Delaware***Considered on reaffirmation calendar.***HOUSE ACTION: POLICIES H-285.998 H-320.939 AND H-320.968 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support the establishment of ICD codes that cover and fully describe prior authorization processes and any and all other administrative and bureaucratic obstacles that may cause or in part contribute to a patient's morbidity or mortality by both delay, as well as denial, of services.

702. PEER SUPPORT GROUPS FOR SECOND VICTIMS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS

See Policy D-405.980

RESOLVED, That our American Medical Association encourage institutional, local, and state physician wellness programs to consider developing voluntary, confidential, and non-discoverable peer support groups to address the “second victim phenomenon”; and be it further

RESOLVED, That our AMA work with other interested organizations to encourage that any future surveys of physician burnout should incorporate questions about the prevalence and potential impact of the “second victim phenomenon” on our physician workforce.

703. PRESERVATION OF THE PATIENT-PHYSICIAN RELATIONSHIP
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association, in an effort to improve professional satisfaction among physicians while also enhancing patient care, conduct a study to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, as well as identify healthcare work environment factors that impact a physician’s ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter, and report back at the 2020 Interim Meeting.

704. PRIOR AUTHORIZATION REFORM
Introduced by Delaware

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED

See Policy D-320.982

RESOLVED, That our American Medical Association explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

705. PHYSICIAN REQUIREMENTS FOR COMPREHENSIVE STROKE CENTER DESIGNATION**Introduced by Thomas J. Madejski, MD, Delegate***Reference committee hearing: see report of Reference Committee G.***HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association advocate for changing the following two provisions from The Joint Commission Stroke Center Requirements:

1. Stroke procedurists should not be required to perform 15 mechanical thrombectomies per year to qualify for taking endovascular call at designated stroke hospitals; and
2. Stroke procedurists should be able to take call at more than one hospital at a time.

706. HOSPITAL FALLS AND “NEVER EVENTS” - A NEED FOR MORE IN DEPTH STUDY*Reference committee hearing: see report of Reference Committee G.***HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED***See Policy D-450.952*

RESOLVED, That our American Medical Association work with interested state medical associations and national medical specialty societies to support research regarding the feasibility and impact of removing patient falls with injury from Medicare’s list of “never events.”

707. COST OF UNPAID PATIENT DEDUCTIBLES ON PHYSICIAN STAFF TIME**Introduced by Illinois***Considered on reaffirmation calendar.***HOUSE ACTION: POLICIES H-165.828, H-165.849 AND D-190.974 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for legislation that brings an end to insurance company practices that make it the physician’s responsibility to recoup patient out-of-pocket costs and deductibles created by health plans.

708. ACCESS TO PSYCHIATRIC TREATMENT IN LONG-TERM CARE**Introduced by American Association for Geriatric Psychiatry, American Psychiatric Association***Reference committee hearing: see report of Reference Committee G.***HOUSE ACTION: ADOPTED AS FOLLOWS
POLICY D-120.951 REAFFIRMED***See Policy D-120.951*

RESOLVED, That our AMA ask Centers for Medicare and Medicaid Services (CMS) to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications.

709. PROMOTING ACCOUNTABILITY IN PRIOR AUTHORIZATION
Introduced by American Association of Neurological Surgeons, Congress of Neurological Surgeons

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED

See Policy D-320.983

RESOLVED, That our AMA study the frequency by which health plans and utilization review entities are using peer-to-peer review prior authorization processes, and the extent to which these processes reflect AMA policies, including H-285.987, “Guidelines for Qualifications of Managed Care Medical Directors,” H-285.939, “Managed Care Medical Director Liability,” H-320.968, “Approaches to Increase Payer Accountability,” and the AMA Code of Medical Ethics Policy E-10.1.1, “Ethical Obligations of Medical Directors,” with a report back to the House of Delegates at the 2020 Annual Meeting.

710. COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE ATTESTATION
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED

See Policy D-275.952

RESOLVED, That our American Medical Association work with the Council for Affordable Quality Healthcare (CAQH) and any other relevant organizations to reduce the frequency of required CAQH reporting to twelve months or longer unless the physician has a change in relevant information to be updated.

711. EFFECTS OF HOSPITAL INTEGRATED SYSTEM ACCOUNTABLE CARE ORGANIZATIONS

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED

See Policy H-160.892

RESOLVED, That our American Medical Association encourage studies into the effect of hospital integrated system Accountable Care Organizations’ (ACOs) ability to generate savings and the effect of these ACOs on medical staffs and potential consolidation of medical practices.

**712. PROMOTION OF EARLY RECOGNITION AND TREATMENT OF SEPSIS BY
OUT-OF-HOSPITAL HEALTHCARE PROVIDERS TO SAVE LIVES**

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED

See Policy D-160.917

RESOLVED, That our American Medical Association work with interested national medical specialty societies to promote the importance of early detection and treatment of sepsis by physicians.

713. SELECTIVE APPLICATION OF PRIOR AUTHORIZATION

**Introduced by American College of Rheumatology, American Academy of Ophthalmology,
American Association of Clinical Endocrinologists, American Society of Clinical Oncology**

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: POLICY H-320.939 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support policies such that prior authorization requirements will not be applied to items or services ordered by physicians and other health care practitioners:

- (i) whose prescribing or ordering practices align with an evidence-based guideline established or approved by a national professional medical association; or
- (ii) who meet quality (e.g. gold standard) criteria; or
- (iii) whose orders or prescriptions are routinely approved; or
- (iv) who adhere to a high quality clinical care pathway; or
- (v) who participate in an alternative payment model or care delivery model that aims to improve health care quality.

714. MEDICARE ADVANTAGE STEP THERAPY

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
See Policy D-320.981

RESOLVED, That our AMA believes that step therapy programs create barriers to patient care and encourages health plans to instead focus utilization management protocol on review of statistical outliers; and be it further

RESOLVED, That our AMA advocate that the Medicare Advantage step therapy protocol, if not repealed, should feature the following patient protections:

1. Enable the treating physician, rather than another entity such as the insurance company, to determine if a patient “fails” a treatment;
2. Exempt patients from the step therapy protocol when the physician believes the required step therapy treatments would be ineffective, harmful, or otherwise against the patients’ best interests;
3. Permit a physician to override the step therapy process when patients are stable on a prescribed medication;
4. Permit a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant medical characteristics of the patient and the known characteristics of the drug regimen; if patient comorbidities will cause, or will likely cause, an adverse reaction or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity;
5. Include an exemption from step therapy for emergency care;
6. Require health insurance plans to process step therapy approval and override request processes electronically;
7. Not require a person changing health insurance plans to repeat step therapy that was completed under a prior plan; and
8. Consider a patient with recurrence of the same systematic disease or condition to be considered an established patient and therefore not subject to duplicative step therapy policies for that disease or condition.

715. MANAGING PATIENT-PHYSICIAN RELATIONS WITHIN MEDICARE ADVANTAGE PLANS
Introduced by Texas

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES H-285.947, H-390.849 AND H-406.991 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate that Medicare Advantage plans allow a primary care physician to remove patients from his or her patient panel if the physician has proven he or she has been unable to establish a patient-physician relationship, despite multiple documented attempts; and be it further

RESOLVED, That our AMA advocate that physicians' Healthcare Effectiveness Data and Information Set and other quality scores and ratings not be affected by patients with whom the physician has been unable to establish a patient-physician relationship.

716. HEALTH PLAN CLAIM AUDITING PROGRAMS
Introduced by Texas

Considered on reaffirmation calendar.

**HOUSE ACTION: POLICIES H-285.998, H-320.939, H-320.948, H-330.921 AND D-70.971 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association vigorously oppose the exclusive use of software or other methodologies, with no review of the patient's medical record, to determine payment and/or denial of a claim based solely on the CPT codes, ICD-10 codes, and modifiers submitted on the claim; and be it further

RESOLVED, That our AMA vigorously oppose the exclusive use of the patient's medical claim history, with no review of the patient's medical record, as a tool to deny or pay a claim; and be it further

RESOLVED, That our AMA vigorously support the use of coding methods that adhere to CPT guidelines, rules, and conventions.

717. REENTRY INTO PHYSICIAN PRACTICE

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
See Policy H-230.953

RESOLVED, That our American Medical Association encourage hospitals to establish alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges; and be it further

RESOLVED, That our AMA encourage The Joint Commission and other accrediting organizations to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges.

718. ECONOMIC DISCRIMINATION IN THE HOSPITAL PRACTICE SETTING
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association actively oppose policies that limit a physician's access to hospital services based upon the number of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation.

719. INTERFERENCE WITH PRACTICE OF MEDICINE BY THE
NUCLEAR REGULATORY COMMISSION

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
See Policy D-455.993

RESOLVED, that our AMA express its opposition to the imminent proposed changes to the Section 10 CFR Part 35.390(b) by the Nuclear Regulatory Commission (NRC) which would weaken the requirements for Authorized Users of Radiopharmaceuticals (AUs), including shortening the training and experience requirements, the use of alternative pathways for AUs, and expanding the use of non-physicians, with AMA advocacy for such opposition during the open comment period ending July 3, 2019.