MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY

DONALD C. BARTON, MD
Introduced by Kentucky Medical Association

WHEREAS, Donald C. Barton, MD was born March 23, 1935 and passed away on April 7, 2018; and

WHEREAS, Dr Barton was a tireless supporter of the medical community in Kentucky for more than 47 years; and

WHEREAS, Dr Barton was a life member of the Kentucky Medical Association; and

WHEREAS, Dr Barton served as President of the Kentucky Medical Association (KMA) from 1987-1988, KMA Vice President from 1985-1986, KMA Board Chair from 1983-1984 and Trustee from the 15th District from 1978-1984; and

WHEREAS, Dr Barton utilized his knowledge as a family practice physician to serve as a Delegate followed by service as Senior Delegate to the American Medical Association for more than 20 years; and

WHEREAS, Dr. Barton served as Chair of the Southeastern Delegation to the AMA from 1995-1997; and

WHEREAS, Dr Barton served from 1980-1988 as one of only 10 physicians from across the United States on the Reagan-Bush National Advisory Committee; and

WHEREAS, Dr Barton honorably served his country as a Captain in the United States Airforce from 1966-1968 and was the recipient of the Air Medal and Bronze Star; and

WHEREAS, Dr Barton was the recipient of the Doctor of the Year honors in 1991; and

WHEREAS, Dr Barton was the recipient of the KMA's Distinguished Service Award in 1993; and

WHEREAS, Dr Barton will be remembered as a strong advocate for patients and the body of medicine having been quoted saying "The number one priority remains the same-you have to be the patient's advocate and love the patient and you'll do well. Medicine will continue to survive as the greatest profession there is."; and

WHEREAS, Dr Barton is survived by his wife of 64 years, Joan and their four children: Donna Vance, Becky Myers, Toni Alton and David Barton, numerous grandchildren and great-grandchildren; and

WHEREAS, Dr Barton will be deeply missed by his family and colleagues; be it therefore

RESOLVED, That our American Medical Association do hereby honor the contributions of Dr Barton and his years of service to organized medicine and the countless patients whose lives were touched by his hard work and dedication; and be it further

RESOLVED, That our AMA extend its sympathy to the family of Dr Barton and present them with a copy of this resolution.

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 10. The following resolutions were handled on the reaffirmation calendar: 101, 106, 107, 110, 112, 113, 206, 207, 210, 213, 214, 220, 228, 234, 406, 415, 501, 510, 519, 520, 708 and 709.

1. DISCRIMINATORY POLICIES THAT CREATE INEQUITIES IN HEALTH CARE
Introduced by New York

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

HOUSE ACTION: ADOPTED
See Policy H-65.963

RESOLVED, That our American Medical Association speak against policies that are discriminatory and create even greater health disparities in medicine; and be it further

RESOLVED, That our AMA be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.

2. FMLA EQUIVALENCE
Introduced by Medical Student Section

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

HOUSE ACTION: ADOPTED
TITLE CHANGED
See Policy H-270.951

RESOLVED, That our American Medical Association advocate that Family and Medical Leave Act policies include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

3. RESEARCH HANDLING OF DE-IDENTIFIED PATIENT INFORMATION
Introduced by Medical Student Section

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

HOUSE ACTION: ADOPTED
TITLE CHANGED
See Policy D-315.975

RESOLVED, That our American Medical Association study the handling of de-identified patient information and report findings and recommendations back to the AMA House of Delegates.

4. PATIENT-REPORTED OUTCOMES IN GENDER CONFIRMATION SURGERY
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-460.893

RESOLVED, That our American Medical Association support initiatives and research developed by specialty societies and other relevant stakeholders to establish standardized protocols for patient selection, surgical management, and preoperative and postoperative care for transgender patients undergoing gender confirmation surgeries; and be it further

RESOLVED, That our AMA support implementation of standardized tools, such as questionnaires developed by specialty societies and other relevant stakeholders to evaluate outcomes of gender confirmation surgeries.

5. DECREASING SEX AND GENDER DISPARITIES IN HEALTH OUTCOMES
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-410.946

RESOLVED, That our American Medical Association support the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and be it further

RESOLVED, That our AMA encourage the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.

6. LIVING DONOR PROTECTION ACT OF 2017 (HR 1270)
Introduced by American Society of Transplant Surgeons

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

HOUSE ACTION: POLICY H-370.965 AMENDED AND
POLICY H-370.996 REAFFIRMED
IN LIEU OF RESOLUTIONS 6 AND 12

Policy H-370.965 amended by addition and deletion to read as follows:

Removing Financial Barriers to Living Organ Donation

1. Our AMA supports federal and state laws that remove financial barriers to living organ donation, such as: (a) provisions for expenses involved in the donation incurred by the organ donor; (b) providing access to health care coverage of any medical expense related to the donation and; (c) provisions for expenses incurred after the donation as a consequence of donation; ~~(c)~~ (d) prohibiting employment discrimination on the basis of living donor status; ~~(d)~~ (e) prohibiting the use of living donor status as the sole basis for denying or limiting health, ~~and~~ life, and disability and long-term care insurance coverage; and ~~(e)~~ (f) provisions to encourage paid leave for organ donation.

2. Our AMA supports legislation expanding paid leave for organ donation.

3. Our AMA advocates that live organ donation surgery be classified as a serious health condition under the Family and Medical Leave Act.

7. OPPOSE THE CRIMINALIZATION OF SELF-INDUCED ABORTION
Introduced by Women Physicians Section

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

HOUSE ACTION: ADOPTED
See Policy H-5.980

RESOLVED, That our American Medical Association oppose the criminalization of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services; and be it further

RESOLVED, That our AMA advocate against any legislative efforts to criminalize self-induced abortion.

8. HEALTH CARE RIGHTS OF PREGNANT MINORS
Introduced by Women Physicians Section

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-60.907

RESOLVED, That our American Medical Association work with appropriate stakeholders to support legislation allowing pregnant minors to consent to related tests and procedures from the prenatal stage through postpartum care; and be it further

RESOLVED, That our AMA oppose any law or policy that prohibits a pregnant minor from consenting to prenatal and other pregnancy related care, including, but not limited to, prenatal genetic testing, epidural block, pain management, Cesarean section, diagnostic imaging, procedures and emergency care.

Resolution 9 was withdrawn.

10. ADVANCING GENDER EQUITY IN MEDICINE

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

HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 10 ADOPTED IN LIEU OF RESOLUTIONS 10, 11, 20 AND 21
See Policy D-65.989

RESOLVED, That our American Medical Association draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting; and be it further

RESOLVED, That our American Medical Association: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement; and be it further

RESOLVED, That our American Medical Association (AMA) recommend as immediate actions to reduce gender bias (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits; and be it further

RESOLVED, That our AMA collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity; and be it further

RESOLVED, That our AMA commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

11. WOMEN PHYSICIAN WORKFORCE AND GENDER GAP IN EARNINGS-MEASURES TO IMPROVE EQUALITY
Introduced by American College of Gastroenterology

Resolution 11 was considered with Resolutions 10, 20 and 21. See Resolution 10.

RESOLVED, That our American Medical Association, together with the assistance of professional medical societies, create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; and be it further

RESOLVED, That our AMA, together with the assistance of professional medical societies, help U.S. public medical schools and facilities create guidance for institutional transparency of compensation, and regular gender-based pay audits, in order to narrow the gender inequity in pay and promotion; and be it further

RESOLVED, That our AMA recommend to eliminate the question of prior salary information from job applications for physician recruitment in academic and private practice.

12. COSTS TO KIDNEY DONORS
Introduced by Illinois

Resolution 12 was considered with Resolution 6. See Resolution 6.

RESOLVED, That our American Medical Association seek legislation to ensure that living kidney donors are reimbursed for expenses associated with donation of their kidney.

13. OPPOSING SURGICAL SEX ASSIGNMENT OF INFANTS WITH DIFFERENCES OF SEX DEVELOPMENT
Introduced by Michigan

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

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association oppose the assignment of gender binary sex to infants with differences in sex development through surgical intervention outside of the necessity of physical functioning for an infant and believes children should have meaningful input into any gender assignment surgery.

14. PROMOTION OF LGBTQ-FRIENDLY AND GENDER-NEUTRAL INTAKE FORMS
Introduced by Michigan

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-315.974

RESOLVED, That our American Medical Association will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community-based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," to our membership.

15. HUMAN TRAFFICKING/SLAVERY AWARENESS
Introduced by Oklahoma

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-170.992

RESOLVED, That our American Medical Association study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.

16. UTILIZATION OF "LGBTQ" IN RELEVANT PAST AND FUTURE AMA POLICIES
Introduced by GLMA: Health Professionals Advancing LGBT Equality

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

HOUSE ACTION: ADOPTED
See Policy D-65.990

RESOLVED, That our American Medical Association utilize the terminology "lesbian, gay, bisexual, transgender, and queer" and the abbreviation "LGBTQ" in all future policies and publications when broadly addressing this population; and be it further

RESOLVED, That our AMA revise all relevant and active policies to utilize the abbreviation "LGBTQ" in place of the abbreviations "LGBT" and "GLBT" where such text appears; and be it further

RESOLVED, That our AMA revise all relevant and active policies to utilize the terms "lesbian, gay, bisexual, transgender, and queer" to replace "lesbian, gay, bisexual, and transgender" where such text appears.

17. REVISED MISSION STATEMENT OF THE AMA
Introduced by New Jersey

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

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association consider its current mission statement to read: The AMA promotes professionalism, the art and science of medicine, physician wellness and the betterment of public health.

18. DISCRIMINATION AGAINST PHYSICIANS BY PATIENTS
Introduced by Organized Medical Staff Section

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-65.991

RESOLVED, That our American Medical Association study (1) the prevalence, reasons for and impact of physician, resident/fellow and medical student reassignment based upon patients' requests; (2) hospitals' and other health care systems' policies or procedures for handling patient bias; and (3) the legal, ethical, and practical implications of accommodating or refusing such reassignment requests.

19. STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE
Introduced by Organized Medical Staff Section

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-345.984

RESOLVED, That our American Medical Association determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates with recommendations for action.

20. ADVANCING THE GOAL OF EQUAL PAY FOR WOMEN IN MEDICINE
Introduced by Young Physicians Section

Resolution 20 was considered with Resolutions 10, 11 and 21. See Resolution 10.

RESOLVED, That our American Medical Association draft and disseminate a report clarifying principles of equal pay in medicine that can form the basis for state and specialty society policy-making, as well as for academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting.

21. TAKING STEPS TO ADVANCE GENDER EQUITY IN MEDICINE
Introduced by Young Physicians Section

Resolution 21 was considered with Resolutions 10, 11 and 20. See Resolution 10.

RESOLVED, That our American Medical Association draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, to be submitted to the House for consideration at the 2019 Annual Meeting; and be it further

RESOLVED, That our AMA work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings.

101. MEDICAID REFORM
Introduced by Louisiana

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-165.855, H-290.972 AND D-165.966 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support reform of the Medicaid health care delivery model using the principles of expanded individual choice, individual opportunity, individual and governmental responsibility; and be it further

RESOLVED, That our AMA support reform of the Medicaid healthcare delivery model which provides the individual patient the opportunity and responsibility to make wise choices in their own health care delivery model, and to share in the financial savings when using the Medicaid healthcare delivery system wisely; and be it further

RESOLVED, That our AMA encourage pluralism and patient choice in the Medicaid healthcare delivery model by requesting the Centers for Medicare and Medicaid Services develop multiple patient choice healthcare payment options at the Federal level, or by approving waivers at the state level, that include but are not limited to the following:

Option 1: Maintenance of the traditional legacy Medicaid program whereby the recipient is allotted a defined contribution per member per month and is provided a government issued identification card, which upon presentation entitles that recipient to receive healthcare services from any willing provider according to a defined benefit package and prescription formulary. Recipients desiring expanded healthcare services or pharmacy benefits may obtain this by paying the additional cost out-of-pocket.

Option 2: Creation of a Medicaid Advantage program similar to a Medicare Advantage program where the defined Medicaid contribution for the recipient is assigned to a third party which in turn must provide the health care services to the recipient. This third party then utilizes the principles of managed care to generate savings which can then be applied to the recipient in the form of expanded services and pharmacy benefits.

Option 3: Creation of a Medicaid voucher system whereby the recipient could then apply that Medicaid defined contribution toward the purchase of private healthcare coverage of their choice. The recipient could choose a coverage plan similar to the defined benefit package of traditional Medicaid, and if they could find such coverage for a lower premium the recipient could apply the savings toward the purchase of expanded service or pharmacy benefit. The premium for that basic benefit packaged could be required by insurance rule never to be more than the defined contribution amount provided by Medicaid. This protects the recipient from excess personal expense. The recipient could also choose to contribute employer sponsored health care plan premium funds, personal funds, or other funds such as a those provided by a philanthropic organization to expand the premium and thus choose to enhance the healthcare or pharmacy benefit.

Option 4: Creation of a Medicaid Medical Savings Account program in which the Medicaid defined contribution allotted for each recipient is then assigned to an account created for the recipient. The recipient can then choose the health care delivery model best for them, with the cost then assigned to that model. Healthcare coverage is maintained for wellness care, illness care and accident care by participation in in a health system payment model, but the recipient is incentivized to maintain healthy lifestyle and judiciously use the healthcare delivery system by sharing in any savings they help to create. These savings can then be used contemporaneously to acquire expanded healthcare or pharmacy services, or be retained in that recipient account until such time as they reach the age of eligibility for Medicare. Those lifetime accumulated savings could then be used to purchase Medicare supplemental insurance coverage, or the savings could be transferred to the recipient's Social Security or other retirement plan for any use in their retirement years.

102. EFFECTIVENESS OF RISK ASSESSMENT MODELS IN REPRESENTING HEALTHCARE RESOURCES EXPENDED FOR INFANTS AND CHILDREN
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-285.903

RESOLVED, That our American Medical Association support risk modeling that appropriately represents care that is specific to all age groups including infants, children, and adolescents as unique risk strata; and be it further

RESOLVED, That our AMA advocate that health insurance organizations transparently publish their risk adjustment models so that clinicians can more effectively document care that reflects patient risk and so that clinicians can assess whether the risk adjustment model appropriately defines the risk of their patients.

103. OPPOSE MEDICAID ELIGIBILITY LOCKOUT
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-290.960

RESOLVED, That our American Medical Association oppose 'lock-out' provisions that exclude Medicaid eligible persons for lengthy periods and support provisions that permit them to reapply immediately for redetermination.

104. EMERGENCY OUT OF NETWORK SERVICES
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-285.904

RESOLVED, That our American Medical Association advocate for the principles delineated in HOD Policy H-285.904 for all health plans, including ERISA plans; and be it further

RESOLVED, That Policy H-285.904 be reaffirmed.

105. USE OF HIGH MOLECULAR WEIGHT HYALURONIC ACID
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-165.856, H-185.964, H-385.942, H-410.961 AND H-450.935 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for reimbursement and national coverage for high molecular weight hyaluronic acid intraarticular injections as appropriate care and treatment for patients with mild to moderate osteoarthritis of the knee.

106. PROHIBIT RETROSPECTIVE ER COVERAGE DENIAL
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-130.970 AND H-285.904 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association actively work toward ensuring strong enforcement of federal and state laws which require health insurance companies to cover emergency room care when a patient reasonably believes they are in need of immediate medical attention, including the imposition of meaningful financial penalties on insurers who do not comply with the law.

107. OPPOSITION TO MEDICAID WORK REQUIREMENT
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-290.961 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm Policy H-290.961 which opposes work requirements as a criterion for Medicaid eligibility.

108. EXPANDING AMA'S POSITION ON HEALTHCARE REFORM OPTIONS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our AMA rescind HOD Policy H-165.844; and be it further

RESOLVED, That our AMA rescind HOD Policy H-165.985; and be it further

RESOLVED, That our AMA amend HOD Policy H-165.888 by deletion as follows:

Evaluating Health System Reform Proposals

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
   A. Physician's maintain primary ethical responsibility to advocate for their patients' interests and needs.
   B. ~~Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.~~
   C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
   D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and

other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients; and be it further

RESOLVED, That our AMA amend HOD Policy H-165.838 by deletion as follows:

Health System Reform Legislation

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

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

109. MEDICAID COVERAGE OF FITNESS FACILITY MEMBERSHIPS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association support Medicaid coverage of fitness facility memberships as a standard preventive health insurance benefit for patients.

110. RETURN TO PRUDENT LAYPERSON STANDARD FOR EMERGENCY SERVICES
Introduced by Missouri

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-130.970 AND H-285.904 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association oppose the arbitrary denial of payment for emergency services based on diagnostic coding alone and support the use of the prudent layperson standard.

111. MEDICARE COVERAGE FOR DENTAL SERVICES
Introduced by American College of Cardiology

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association reaffirm appreciation and gratitude for the valuable contributions dental health professionals make to Americans' health and well-being as members of our healthcare team; and be it further

RESOLVED, That our AMA promote and support legislative and administrative action to include preventive and therapeutic dental services as a standard benefit for all Medicare recipients.

112. ENABLING ATTENDING PHYSICIANS TO WAIVE THE THREE-MIDNIGHT RULE FOR PATIENTS RECEIVING CARE WITHIN DOWNSIDE RISK SHARING ACCOUNTABLE CARE ORGANIZATIONS AND ADVANCE BUNDLED PAYMENTS CARE IMPROVEMENT PROGRAMS
Introduced by AMDA - The Society for Post-Acute and Long-Term Care Medicine

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-280.947 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support provisions that allow attending physicians caring for Medicare recipients in any setting be allowed to waive the three midnight inpatient stay requirement for initiation of skilled nursing care in a facility when the attending physician and the skilled nursing facility are both part of a downside risk sharing arrangement with Medicare--such as a Track 1+ or higher Medicare Accountable Care Organization or an Advanced Bundled Payments for Care Improvement Program.

113. SURVIVORSHIP CARE PLANS
Introduced by American Society of Clinical Oncology

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-55.969 AND H-70.919 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study challenges in billing and coding for cancer survivorship care and invite collaboration from internal medicine and specialty societies for guideline development and implementation; and be it further

RESOLVED, That our AMA prioritize assignation of distinct ICD-10 and E&M codes associated with cancer survivorship care, and collaborate with the Centers for Medicare and Medicaid Services implementation in order to provide standards of care and reimbursement for survivorship care plans.

114. INCLUSION OF BUNDLED PAYMENTS CARE IMPROVEMENT (BPCI) POST-ACUTE ONLY MODEL 3 IN ADVANCED BPCI
Introduced by AMDA - The Society for Post-Acute and Long-Term Care Medicine

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-385.954

RESOLVED, That our American Medical Association work with interested national medical specialty societies to help develop and advocate for one or more Medicare alternative payment models focusing on post-acute and / or long-term care.

115. EXPANDING ON-SITE PHYSICIAN HOME HEALTH CARE TO LOW-INCOME FAMILIES AND THE CHRONICALLY ILL
Introduced by Maryland

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-210.981

RESOLVED, That our American Medical Association amend Policy H-210.981, "On-site Physician Home Health Care," by addition and deletion to read as follows:

The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can ~~only~~ be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.
(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or ~~excessively tiring and painful for~~ detrimental to the patient's health.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, including the development of programs for low-income families and older adults.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, ~~and~~ severity of illness, and socioeconomic status.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.

116. BAN ON MEDICARE ADVANTAGE "NO CAUSE" NETWORK TERMINATIONS

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 116 ADOPTED
See Policies H-285.908, H-285.991, D-285.961 and D-285.988

RESOLVED, That our AMA develop a set of reform proposals addressing the way that Medicare Advantage plans develop and modify their physician networks with the aim of improving the stability of networks, the ability of patients to obtain needed primary and specialty care from in-network physicians, physician satisfaction, and communication with patients about network access with report back to the House of Delegates at the 2019 Annual Meeting; and be it further

RESOLVED, That our AMA amend Policy D-285.988, by addition to read as follows:

1. Our AMA will draft model state legislation and amend the AMA's Model Managed Care Contract to reflect AMA policy regarding the marketing of physicians as network participants.
2. Our AMA will seek legislation or regulation that would prohibit Medicare managed care companies from terminating without cause an enrollee's contracted physician before the enrollee's first subsequent open enrollment period;

and be it further

RESOLVED, That our AMA reaffirm Policy H-285.908, which supports requiring that provider terminations without cause be done prior to the enrollment period, and supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer's letter notifying patients of the provider's change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution; and be it further

RESOLVED, That our AMA reaffirm Policy H-285.991, which outlines that prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine.

117. SUPPORTING RECLASSIFICATION OF COMPLEX REHABILITATION TECHNOLOGY
Introduced by Texas

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate for the Centers for Medicare & Medicaid Services to reclassify complex rehabilitation technology as a separate and distinct payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs.

118. PAYMENT FOR ADVANCE CARE PLANNING
Introduced by Arizona

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICY H-390.916 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek Federal legislation to require Medicare Advantage, Medicaid, and commercial insurance to pay for advance care planning whenever the patient's physician believes that it is appropriate.

119. PAYMENT FOR PALLIATIVE CARE
Introduced by Arizona

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-70.915, H-85.951 AND H-85.966 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek Federal legislation to require Medicare, Medicare Advantage, Medicaid, and commercial insurance to pay for palliative care, regardless of site of care, whenever the patient's physician believes that it is appropriate and the patient, or surrogate decision maker, agrees.

201. REMOVING BARRIERS TO OBESITY TREATMENT
Introduced by Obesity Medicine Association, Colorado, Minority Affairs Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-440.954

RESOLVED, That our American Medical Association work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and be it further

RESOLVED, That our AMA work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

202. UNIVERSAL AND STANDARDIZED PROTOCOLS FOR EHR DATA TRANSITION
Introduced by Virginia, North Carolina, South Carolina, Mississippi, Maryland, Tennessee, American Urological Association, American Association of Clinical Urologists

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
ADDITIONAL PROPOSED RESOLVE REFERRED FOR DECISION
See Policy D-478.972

RESOLVED, That our American Medical Association seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce

common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data.

PROPOSED RESOLVE CLAUSE REFERRED FOR DECISION:
RESOLVED, That regulations that require universal and standard interoperability protocols be promulgated within twenty-four (24) months of such legislative or regulatory direction to the Office of National Coordinator of Healthcare IT (ONC), with the ONC to establish a compliance deadline for the EHR vendors that is as expedient as practicable and not to exceed thirty-six (36) months from promulgation of the regulations by the ONC.

203. UPDATING FEDERAL FOOD POLICY TO IMPROVE NUTRITION AND HEALTH
Introduced by District of Columbia

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-440.978

RESOLVED, That our American Medical Association amend existing AMA Policy D-440.978, "Culturally Responsive Dietary and Nutritional Guidelines," by addition to read as follows:

D-440.978, Culturally Responsive Dietary and Nutritional Guidelines.
Our AMA and its Minority Affairs Section will: (1) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (2) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; (3) recognize that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often manifesting in childhood; and (~~3~~4) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care.

and be it further

RESOLVED, That our AMA propose legislation that modifies the National School Lunch Act, 42 U.S.C. § 1758, so as to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cow's milk; and be it further

RESOLVED, That our AMA recommend that the U.S. Department of Agriculture and U.S. Department of Health and Human Services clearly indicate in the Dietary Guidelines for Americans and other federal nutrition guidelines that meat and dairy products are optional, based on an individual's dietary needs.

204. OPPOSITION TO MANDATED PROFICIENCY IN EHR FOR LICENSURE
Introduced by Louisiana

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-478.993

RESOLVED, That our American Medical Association adopt a policy that provides that no physician should be denied a medical license on the grounds of failure to use an electronic health record or failure to demonstrate proficiency in use of an electronic health record.

205. AUGMENTED INTELLIGENCE
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RESOLUTION 205 CONSIDERED WITH BOARD OF TRUSTEES REPORT 41, WHICH WAS ADOPTED AS AMENDED IN LIEU OF RESOLUTION 205

RESOLVED, That our American Medical Association develop Augmented Intelligence (AI) policy that reflects the principle that all patients should have 24-7 access to primary care physicians who can see the medical records of the patients; and be it further

RESOLVED, That AI should be funded as an enhancement of the primary care medical home so that patients who really need AI can benefit from the technology and such that AI does not become a requirement that must be incorporated into the care of every patient.

206. APPROPRIATE USE OF TELEHEALTH SERVICES
Introduced by American Academy of Pediatrics

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-480.946 AND H-480.974 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with relevant stakeholders to ensure that all telehealth services are provided by and organized within the confines of the medical home, including financial incentives to utilize the telehealth modality outside the medical home; and be it further

RESOLVED, That our AMA advocate at both the state and national level that all telehealth vendors be required to collect and report quality measures in the context of clinical guidelines developed by reputable national specialty organizations; and be it further

RESOLVED, That our AMA work with relevant stake holders to accumulate quality of care, patient satisfaction, and outcome data to compare telehealth with face-to-face care.

207. QUALITY IMPROVEMENT REQUIREMENTS
Introduced by American Academy of Pediatrics

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-450.947 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association develop a quality improvement initiative so that if physicians complete quality improvement requirements of their specialty boards, that payers, hospitals, and licensing agencies will accept the specialty board certification evidence that physicians are practicing good medicine and will not require physicians to meet separate quality improvement requirements of payers, hospitals, and licensing agencies.

208. PRIOR AUTHORIZATION REQUIREMENTS FOR POST-OPERATIVE OPIOIDS
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association strongly oppose prior authorization requirements for postoperative analgesia equivalent to five days or less so as to prevent patient suffering.

209. SUBSTANCE USE DISORDERS DURING PREGNANCY
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-420.950 and H-420.969

RESOLVED, That our American Medical Association reaffirm Policy H-420.969 (#4) so as to oppose any legislation that seeks to specifically penalize women who are diagnosed with a substance abuse disorder during pregnancy; and be it further

RESOLVED, That our AMA oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse; and be it further

RESOLVED, That our AMA support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy.

210. BANNING THE SALE OF BUMP STOCKS
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-145.985, H-145.993 AND H-145.997 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support legislation that blocks the sale of any device or modification, including but not limited to bump stocks, that functionally converts a firearm into a weapon that mimics fully-automatic operation; and be it further

RESOLVED, That our AMA support legislation that would ban the sale and/or ownership of high capacity magazines or clips and high-speed-high-destruction rounds.

211. CLARIFICATION FROM US DEPARTMENT OF JUSTICE REGARDING FEDERAL ENFORCEMENT OF MEDICAL MARIJUANA LAWS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-95.969

RESOLVED, That our American Medical Association when necessary and prudent seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians.

212. VALUE-BASED PAYMENT SYSTEM
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association work to repeal the law that conditions a portion of a physician's Medicare payment on compliance with the Medicare Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM) programs; and be it further

RESOLVED, That our AMA continue advocating for a reduction in the administrative burdens of compliance with value-based programs and that these programs comply with evidence-based standards.

213. UTILIZATION REVIEW
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-320.942, H-320.948, H-320.973, H-320.986, H-320.988, H-320.995, H-335.999 AND D-320.995 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek legislation/regulation that requires insurance companies, peer review organizations and the Centers for Medicare and Medicaid Services to use the review criteria that existed at the time that services were provided when making their determinations.

214. STRENGTHENING THE BACKGROUND CHECK SYSTEM FOR FIREARM SALES
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-145.991 AND H-145.992 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support legislation that requires a waiting period and background checks prior to the purchase of all firearms, including the person-to-person transfer, internet sales, and interstate transactions of all firearms.

215. REGULATION OF HOSPITAL ADVERTISING
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-225.994 AMENDED IN LIEU OF RESOLUTION 215

Policy H-370.965 amended by addition to read as follows:

Hospital Advertising in Printed and Broadcast
In order to prevent medical misinformation, the AMA encourages (1) medical staff participation in hospital administration decisions regarding marketing and advertising, and (2) hospital and medical advertising be consistent with federal regulatory standards and with the *Code of Medical Ethics*.

216. FDA CONFLICT OF INTEREST
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate that the Food and Drug Administration place a greater emphasis on a candidate's conflict of interest when selecting members for advisory committees; and be it further

RESOLVED, That our AMA advocate for a reduction in conflict of interest waivers granted to Advisory Committee candidates.

217. REFORMING THE ORPHAN DRUG ACT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support efforts to reform the Orphan Drug Act by closing loopholes identified by the Food and Drug Administration in order to protect the Act's original intent of promoting therapies targeting rare diseases; and be it further

RESOLVED, That our AMA support increased transparency in development costs, post-approval regulation and overall earnings for pharmaceuticals designated as "Orphan Drugs"; and be it further

RESOLVED, That our AMA support modifications to the exclusivity period of "Orphan Drugs" to increase access to these pharmaceutical drugs for patients with rare diseases.

218. CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-525.974

RESOLVED, That our American Medical Association encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and be it further

RESOLVED, That our AMA work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge the appropriate type and quantity of feminine hygiene products, including tampons for their needs.

219. IMPROVING MEDICARE PATIENTS' ACCESS TO KIDNEY TRANSPLANTATION
Introduced by American Society of Transplant Surgeons

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED FOR DECISION

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 the "Dialysis PATIENTS Demonstration Act of 2017" (S. 2065) (HR 4143); and be it further

RESOLVED, That the House of Delegates receive a report back at the 2018 Interim Meeting regarding our AMA actions in opposing the PATIENTS Act

220. BAN ON SEMI-AUTOMATIC ASSAULT WEAPONS AND HIGH CAPACITY AMMUNITION MAGAZINES
Introduced by California

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-145.985 AND H-145.993 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association urge Congress to pass legislation to ban the sale, transfer, manufacture, and importation of assault weapons and high-capacity ammunition magazines to the American public.

221. MAINTAINING VALIDITY AND COMPREHENSIVENESS OF U.S. CENSUS DATA
Introduced by American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-350.952

RESOLVED, That our American Medical Association support adequate funding for the U.S. Census to assure accurate and relevant data is collected and disseminated.

222. SUPPORT THE ELIMINATION OF BARRIERS TO MEDICATION-ASSISTED TREATMENT FOR SUBSTANCE USE DISORDER

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 222 ADOPTED IN LIEU OF RESOLUTIONS 222 AND 240
See Policy D-95.968

RESOLVED, That our American Medical Association advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and be it further

RESOLVED, That our AMA develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.

223. TREATING OPIOID USE DISORDER IN HOSPITALS
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 239
See Policy D-95.967

RESOLVED, That our American Medical Association's Opioid Task Force work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease; and be it further

RESOLVED, That our AMA advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder; and be it further

RESOLVED, That our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations.

224. LEGALIZATION OF INTERPHARMACY TRANSFER OF ELECTRONIC CONTROLLED SUBSTANCE PRESCRIPTIONS
Introduced by American Society of Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-120.923

RESOLVED, That our American Medical Association advocate for the removal of state, federal and other barriers that impede interpharmacy transfers of valid electronic prescriptions for Schedule II-V medications.

225. PHARMACY BENEFIT MANAGERS IMPACT ON PATIENTS
Introduced by American Society of Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-120.933

RESOLVED, That our American Medical Association gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship; and be it further

RESOLVED, That our AMA examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts; and be it further

RESOLVED, That our AMA request from PBMs and compile data on the top twenty-five medication pre-certification requests and the percent of such requests approved after physician challenge.

226. MODEL STATE LEGISLATION FOR ROUTINE PREVENTATIVE PROSTATE CANCER SCREENING FOR MEN AGES 55-69
Introduced by American Urological Association,
American Association of Clinical Urologists, Virginia

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association develop model state legislation for screening of asymptomatic men ages 55-69 for prostate cancer after informed discussion between patients and their physician without annual deductible or co-pay.

227. AN OPTIONAL NATIONAL PRESCRIPTION DRUG FORMULARY
Introduced by Florida

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association develop a set of principles for a National Prescription Drug Formulary (NPD Formulary) that are designed to lower prescription drug prices to the patient, and be transparent, independent, non-profit, and fee-based, with a report back to the AMA HOD at the 2018 Interim Meeting; and be it further

RESOLVED, That our AMA produce model legislation for an NPD Formulary with input from appropriate stakeholders based on a set of principles for such a Formulary that the AMA will develop, and that our AMA join with appropriate stakeholders to advocate that Congress authorize the establishment of this NPD Formulary that will be available to all Americans as an option to their healthcare insurance program in an actuarially appropriate manner.

228. MEDICARE QUALITY INCENTIVES
Introduced by International Medical Graduates Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-390.838 AND D-390.949 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That the American Medical Association work with the Department of Health and Human Services in incentivizing small groups, and more senior physicians, regardless of their volume of patients total billing in dollars, with "small group", and "senior" deferments against penalties and bonuses for continued practice.

229. PERMANENT RESIDENCE STATUS FOR PHYSICIANS ON H1-B VISAS

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 229 ADOPTED
See Policy D-255.979

RESOLVED, That our American Medical Association work with all relevant stakeholders to clear the backlog for conversion from H1-B visas for physicians to permanent resident status.

230. OPPOSITION TO FUNDING CUTS FOR PROGRAMS THAT IMPACT THE HEALTH OF POPULATIONS
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-440.819

RESOLVED, That our American Medical Association actively advocate that Congress, the White House, and senior cabinet officials ensure that programs designed to meet daily needs, support changes in individual behavior, and improve the health of populations remain funded at least at current levels and remain available without additional restrictions or rules.

231. ONLINE CONTROLLED DRUGS
Introduced by Ohio

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-120.982

RESOLVED, That our American Medical Association support efforts that help the Drug Enforcement Administration and the Food and Drug Administration to better regulate and control the illegal online sales and distributions of drugs, dietary supplements and herbal remedies.

232. RECORDING LAW REFORM
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-315.983

RESOLVED, That our American Medical Association draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

233. SUPPORT FOR REAUTHORIZATION OF THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policies H-150.937 and D-150.975

RESOLVED, That our American Medical Association actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives; and be it further

RESOLVED, That AMA Policy D-150.975, which calls for action to remove sugar-sweetened beverages from the Supplemental Nutrition Assistance Program, be reaffirmed; and be it further

RESOLVED, That AMA Policy H-150.937, which in part aims to replace calorie-rich, nutrient-poor food with nutrient-dense food within the Supplemental Nutrition Assistance Program, be reaffirmed.

234. SUPPORT FOR THE PRIMARY CARE ENHANCEMENT ACT
Introduced by Oklahoma

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-380.984 AND H-385.912 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association, pursuant to H-385.912, actively lobby Congress to pass the Primary Care Enhancement Act.

235. HOSPITAL CONSOLIDATION
Introduced by Washington

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets; and be it further

RESOLVED, That our AMA study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist.

236. REDUCING MIPS REPORTING BURDEN
Introduced by Washington

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-395.999

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduces regulatory and paperwork burdens on physicians; and be it further

RESOLVED, That, in the interim, our AMA work with CMS to shorten the yearly MIPS data reporting period from one year to a minimum of 90 days (of the physician's choosing) within the calendar year.

237. SAFE AND EFFICIENT E-PRESCRIBING
Introduced by Craig A. Backs, MD, Delegate

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-120.972

RESOLVED, That our American Medical Association study current e-prescribing processes and make recommendations to improve these processes to make them as safe as possible for patients and as efficient as possible for prescribers.

238. REFORM OF PHARMACEUTICAL PRICING: NEGOTIATED PAYMENT SCHEDULES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support federal legislation that modifies the Hatch-Waxman Act and the Biologics Price Competition and Innovation Act (Biosimilars Act) to institute the replacement of time-specific patent protections with negotiated payment schedules and indefinite exclusivity for U.S. Food and Drug Administration-approved drugs in the Medicare Part D Program.

239. TREATING OPIOID USE DISORDER IN HOSPITALS
Introduced by Illinois

Resolution 239 was considered with Resolution 223. See Resolution 223.

RESOLVED, That our American Medical Association adopt a policy in favor of hospitals in the United States treating opioid use disorder with medications approved by the U.S. Food and Drug Administration for that purpose (buprenorphine, methadone and naltrexone) along with appropriate counseling; and be it further

RESOLVED, That our AMA advocate for legislation, standards, policies and funding to support hospitals in the United States treating opioid use disorder with medications approved by the FDA for that purpose (buprenorphine, methadone and naltrexone) along with appropriate counseling; and be it further

RESOLVED, That our AMA work together with relevant organizations such as the American Hospital Association, The Joint Commission and the American Society of Addiction Medicine to develop and promote a model hospital policy that would assist hospitals in addressing opioid use disorder as a chronic disease by:

a) ensuring that medical and other clinical staff are educated about evidence-based treatment of opioid use disorder in order to appropriately advise and treat their patients,
b) providing patient education about and access to all three FDA-approved medications (buprenorphine, methadone and naltrexone) in emergency and inpatient settings, and buprenorphine and methadone in obstetric settings,
c) maintaining use of these medications for patients already on them,
d) initiating use of these medications for assenting patients affected by the disease,
e) establishing comprehensive discharge plans for ongoing medical and behavioral treatment in the community, and
f) participating in the development of community-wide systems of care for patients with opioid use disorder to facilitate discharge planning.

240. TREATING OPIOID USE DISORDER IN TREATMENT FACILITIES
Introduced by Illinois

Resolution 240 was considered with Resolution 222. See Resolution 222.

RESOLVED, That our American Medical Association adopt a policy that recognizes the use of buprenorphine or methadone as effective treatment for opioid use disorder, and encourages the appropriate use of medication and non-medication-based treatment; and be it further

RESOLVED, That our AMA advocate for legislation to eliminate barriers and require access to all three FDA-approved medications (buprenorphine, methadone and naltrexone) at all legally certified drug treatment facilities, and advocate for standards, policies and funding to support access to these medications at treatment facilities; and be it further

RESOLVED, That our AMA conduct a campaign to increase awareness on the part of providers, treatment programs, and the public that AMA recognizes the use of buprenorphine or methadone as effective treatment for opioid use disorder.

241. ACCURACY AND ACCOUNTABILITY OF PHYSICIAN COMPENSATION REPORTING BY DRUG AND DEVICE COMPANIES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-140.848

RESOLVED, That our American Medical Association advocate that (1) any payment or transfer of value reported as part of the Physician Payments Sunshine Act should include whether the physician acknowledged receipt of said payment or transfer of value and (2) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value; and be it further

RESOLVED, That our AMA advocate that a contested reported payment or transfer of value should be removed immediately from the Open Payments website until the reporting company validates the compensation with verifiable documentation.

242. PHARMACY BENEFIT MANAGERS AND COMPOUNDED MEDICATIONS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-125.986

RESOLVED, That our American Medical Association amend Policy H-125.986 by addition as follows:

H-125.986, Pharmaceutical Benefits Management Companies
Our AMA: (1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;
(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care;
(6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications, and encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest; and
(7) encourages the FTC and FDA to monitor PBM's policies for potential conflicts of interest and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest.

243. ADDRESSING BARRIERS TO REPORTING HEALTH CARE PROVIDER SEX CRIMES

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 243 ADOPTED
See Policy H-515.954

RESOLVED, that our American Medical Association support the efforts and work with the Federation of State Medical Boards to examine disciplinary data, barriers that delay or prevent reporting of sex crimes, and the cooperation of state medical boards with law enforcement in order to ensure a comprehensive approach to identifying and addressing sexual crimes within medicine.

244. INCREASING THE LEGAL AGE OF PURCHASING AMMUNITION AND FIREARMS FROM 18 TO 21
Introduced by Maryland

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-145.985 AMENDED IN LIEU OF RESOLUTIONS 244 AND 248

Policy H-145.985 amended by addition and deletion to read as follows:

It is the policy of the AMA to:

(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of ~~18~~ 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d~~c~~) the imposition of significant licensing fees for firearms dealers;
(e~~d~~) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f~~e~~) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

(4) Oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

245. OPPOSING NCOIL ATTEMPTS TO STOP PHYSICIAN DISPENSING
Introduced by Maryland

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-120.990 AMENDED IN LIEU OF RESOLUTION 245

Policy H-120.990 amended by addition to read as follows:

Physician Dispensing
Our AMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines.

Our AMA oppose legislative and other efforts that are in conflict with AMA policies concerning patient access to physician-dispensed drugs and devices.

246. SUPPORT FOR PATIENTS AND PHYSICIANS IN DIRECT PRIMARY CARE

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 246 ADOPTED
See Policy H-385.912

RESOLVED, That our AMA reaffirm Policy H-385.912, Direct Primary Care; and be it further

RESOLVED, That our AMA support efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.

247. OPPOSED REPLACEMENT OF THE MERIT-BASED INCENTIVE PAYMENT SYSTEM WITH THE VOLUNTARY VALUE PROGRAM
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-395.998

RESOLVED, That our American Medical Association oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined; and be it further

RESOLVED, That our AMA study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program need to be made; and be it further

RESOLVED, That our AMA continue its advocacy efforts to improve the MIPS program, specifically requesting:

1. True EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures,
2. Safe harbor protections for entities providing clinical data for use in the MIPS program,
3. Continued infrastructure support for smaller practices that find participation particularly burdensome,
4. Adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation, and
5. Limiting public reporting of physician performance to those measures used for scoring in the MIPS program; and be it further

RESOLVED, That our AMA determine if population measures are appropriate and fair for measuring physician performance.

248. OPPOSITION TO FIREARM CONCEALED CARRY RECIPROCITY
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Resolution 248 was considered with Resolution 244. See Resolution 244.

RESOLVED, That our American Medical Association, in the interest of safety for all citizens, vigorously oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

249. SUPPORT ANY WILLING PROVIDER LEGISLATION
Introduced by Florida

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association draft and promote model state legislation which:

1. Allows any patient covered by a specific managed care organization to choose to receive medical care from a physician (MD and DO) licensed in that state willing to agree to the terms of that managed care organization's contract, and
2. Allows a physician (MD or DO) licensed in that state willing to agree to the terms of a specific managed care organization's contract to participate in delivering medical services to the patients covered by that managed care organization without being mandated to accept any specific type of insurance or managed care organizations contract.

250. CLARIFICATION OF GUIDELINES FOR ONLINE PRESCRIBERS
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-120.972

RESOLVED, That our American Medical Association support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when a valid patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care.

251. SCOPE OF PRACTICE EXPANSION ADVOCACY AND IMPACTS ON PHYSICIANS AND MEDICAL STUDENTS
Introduced by Arizona

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-160.995

RESOLVED, That our American Medical Association continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; and be it further

RESOLVED, That our AMA advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; and be it further

RESOLVED, That our AMA advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and be it further

RESOLVED, That our AMA study the impact of scope of practice expansion on medical student choice of specialty.

252. REPEAL OF GROUP PURCHASING ORGANIZATIONS AND PHARMACY BENEFIT MANAGER SAFE HARBOR
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association collaborate with medical specialty partners, patient advocacy groups, and other stakeholders to seek repeal of the 1987 Safe Harbor exemption to the Medicare Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and Pharmacy Benefit Managers (PBMs); and be it further

RESOLVED, That our AMA educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages; and be it further

RESOLVED, That our AMA reaffirm Policy H-100.956, which states in part that "Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs."

253. SEPARATION OF CHILDREN FROM THEIR CAREGIVERS AT BORDER
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
IN LIEU OF RESOLUTION 257
TITLE CHANGED
See Policy H-440.818

RESOLVED, That our American Medical Association oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and be it further

RESOLVED, That our AMA urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families.

254. OPPOSITION TO REGULATIONS THAT PENALIZE IMMIGRANTS FOR ACCESSING HEALTH CARE SERVICES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-20.901 and D-440.927

RESOLVED, That our American Medical Association, upon the release of a proposed rule, regulations or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition; and be it further

RESOLVED, That our AMA amend AMA Policy H-20.901 by addition and deletion to read as follows:

Our AMA (1) ~~supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649); (2)~~ recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2 ~~3~~) recommends that non-immigrant travel into the United States not be restricted because of

HIV status; and (3 ~~4~~) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

255. 340B DRUG DISCOUNT PROGRAM
Introduced by American Society of Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH A RESOLVE REFERRED FOR REPORT AT THE 2018 INTERIM MEETING
See Policy H-110.985

RESOLVED, That our American Medical Association advocate for 340B Drug Discount Program (340B program) transparency, including an accounting of covered entities' 340B savings and the percentage of 340B savings used directly to care for underinsured patients and patients living on low-incomes; and be it further

RESOLVED, That our AMA support recommendations to equip the Health Resources and Services Administration (HRSA) with more authority, resources and staff to conduct needed 340B program oversight; and be it further

RESOLVED, That our AMA recognize the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients.

FOLLOWING RESOLVE REFERRED FOR REPORT AT I-18:

RESOLVED, That our AMA support discontinuing the use of the Disproportionate Share Hospital adjustment as a determining measure for 340B program eligibility.

256. DEFINING PHYSICIAN FOR THE FEDERAL AVIATION ADMINISTRATION, THE DEPARTMENT OF TRANSPORTATION AND CONGRESS

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 256 ADOPTED
See Policy D-405.989

RESOLVED, That our American Medical Association advocate for the Federal Aviation Administration, the Department of Transportation and Congress to define a "physician" as an individual possessing degree of either a Doctor of Medicine or Doctor of Osteopathic Medicine.

257. SEPARATION OF CHILDREN FROM THEIR PARENTS AT BORDER
Introduced by American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians

Resolution 257 was considered with Resolution 253. See Resolution 253.

RESOLVED, That our American Medical Association urge the Department of Homeland Security, Attorney General Sessions, and President Trump to withdraw its new policy to require separation of children from their parents, and instead, give priority to supporting families and protecting the health and well-being of the children within those families.

301. PROTECTING MEDICAL TRAINEES FROM HAZARDOUS EXPOSURE
Introduced by Illinois

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association call for the mandatory education of students, residents, physicians and surgeons on the deleterious effects of exposure to hazardous materials; and be it further

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and Liaison Committee on Medical Education to create standards that allow students and trainees to voluntarily avoid exposure to hazardous/biohazard materials without negatively impacting their standing in school or training programs; and be it further

RESOLVED, That our AMA support and encourage the specific option for students or trainees to be able to excuse themselves from exposure to Methylmethacrylate if they are or think they may be pregnant without negatively impacting their standing in their school or training programs; and be it further

RESOLVED, That our AMA support and encourage constant updating of the protection of medical trainees, physicians and surgeons from exposure to hazardous materials during the course of their medical school training and practice, using standards published by the Occupational Safety and Health Administration; the National Institute for Occupational Safety and Health and other Centers for Disease Control and Prevention agencies; the College of American Pathologists; and the American College of Radiology, as well as other relevant resources available for health workers.

302. FOR-PROFIT MEDICAL SCHOOLS OR COLLEGES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-305.954

RESOLVED, That our American Medical Association study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the (1) attrition rate of students; (2) financial burden of non-graduates versus graduates; (3) success of graduates in obtaining a residency position; and (4) level of support for graduate medical education, and report back at the 2019 Annual Meeting.

303. FELLOWSHIP START DATE
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-310.958

RESOLVED, That our American Medical Association work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to evaluate the benefits and drawbacks for all interested parties.

304. PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES DESIGNATED AS A MEDICALLY UNDERSERVED POPULATION
Introduced by American Academy of Physical Medicine and Rehabilitation

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-90.968

RESOLVED, That our American Medical Association advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population; and be it further

RESOLVED, That Policy H-90.968 be reaffirmed.

305. STANDARDIZATION OF MEDICAL LICENSING TIME LIMITS ACROSS STATES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association amend Policy H-275.978, "Medical Licensure," by addition to read as follows:

The AMA:(1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;
(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;
(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;
(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine.(BOT Rep. I-93-13; CME Rep. 10 - I-94);
(7) urges licensing boards to maintain strict confidentiality of reported information;
(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
(10) urges all physicians to participate in continuing medical education as a professional obligation;
(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.
(23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX.

306. SEX- AND GENDER-BASED MEDICINE
Introduced by American Medical Women's Association

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-295.310

RESOLVED, That our American Medical Association work collaboratively with the Liaison Committee on Medical Education and other interested organizations for the inclusion of sex- and gender-based differences within the curricular content for medical school accreditation.

307. HEALTHCARE FINANCE IN THE MEDICAL SCHOOL CURRICULUM
Introduced by Missouri

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association study the extent to which medical schools and residency programs are teaching topics of healthcare finance and medical economics; and be it further

RESOLVED, That our AMA make a formal suggestion to the Liaison Committee on Medical Education encouraging the addition of a new Element, 7.10, under Standard 7, "Curricular Content," that would specifically address the role of healthcare finance and medical economics in undergraduate medical education.

RESOLUTION 308 WAS WITHDRAWN

309. FOREIGN TRAINED IMGS COMPETENCY-BASED SPECIALTY EXAM WITHOUT U.S. RESIDENCY
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 work with other stakeholders including the Accreditation Council of Graduate Medical Education, Association of American Medical Colleges and the American Board of Medical Specialties, to advocate that International Medical Graduates who have completed residency programs in their own countries should be eligible to take the specialties exam without being required to complete additional residency training in the U.S.

RESOLUTION 310 WAS WITHDRAWN

311. OPIOID EDUCATION FOR NEW TRAINEES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-120.985

RESOLVED, That our American Medical Association work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students and physicians in training and practicing physicians.

312. SUICIDE AWARENESS TRAINING
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-295.858

RESOLVED, That our American Medical Association engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians and other health care professionals, using an evidence-based, multidisciplinary approach.

313. FINANCIAL LITERACY FOR MEDICAL STUDENTS AND RESIDENTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-295.316

RESOLVED, That our American Medical Association amend Policy D-295.316 by addition to read as follows:

D-295.316, Management and Leadership for Physicians
1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs ~~between~~ among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.

314. BOARD CERTIFICATION CHANGES IMPACT ACCESS TO ADDICTION MEDICINE SPECIALISTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with the American Board of Addiction Medicine (ABAM) and American Board of Medical Specialties (ABMS) to accept ABAM board certification as equivalent to any other ABMS-recognized Member Board specialty as a requirement to enroll in the transitional maintenance of certification program and to qualify for the ABMS Addiction Medicine board certification examination.

315 PEER-FACILITATED INTERGROUP DIALOGUE TO PROMOTE CULTURAL COMPETENCE AND HUMILITY
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-295.897

RESOLVED, That our American Medical Association encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

316. END "PART 4 IMPROVEMENT IN MEDICAL PRACTICE" REQUIREMENT FOR ABMS MOC®
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association call for an end to the mandatory American Board of Medical Specialties "Part 4 Improvement in Medical Practice" maintenance of certification requirement.

317. EMERGING TECHNOLOGIES (ROBOTICS AND AI) IN MEDICAL SCHOOL EDUCATION
Introduced by Maryland

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association encourage medical schools to evaluate and update as appropriate their curriculum to increase students' exposure to emerging technologies, in particular those related to robotics and artificial intelligence; and be it further

RESOLVED, That our AMA encourage medical schools to provide student access to computational resources like cloud computing services; and be it further

RESOLVED, That our AMA reaffirm H-480.988 which urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and be it further

RESOLVED, That our AMA reaffirm Section 1.2.11 of the AMA Code of Ethics and H 480.996 that states the guidelines for the ethical development of medical technology and innovation in healthcare.

318. AMA CONVENE STAKEHOLDERS TO TRANSITION USMLE TO PASS/FAIL SCORING
Introduced by Nebraska

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-275.953

RESOLVED, That our American Medical Association amend Policy H-275.953, "The Grading Policy for Medical Licensure Examinations," by addition and deletion to read as follows:

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.

2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.

3. Our AMA will ~~work with~~ co-convene the appropriate stakeholders to study ~~alternate means of~~ possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to

avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.

319. ALL PAYER GRADUATE MEDICAL EDUCATION FUNDING
Introduced by Arizona

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy D-305.967

RESOLVED, That our American Medical Association investigate the status of implementation of AMA Policies D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," and D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," and report back to the House of Delegates with proposed measures to resolve the problems of underfunding, inadequate number of residencies and geographic maldistribution of residencies.

320. YOUNG PHYSICIAN INVOLVEMENT IN MAINTENANCE OF CERTIFICATION
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy D-275.954

RESOLVED, That our American Medical Association submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards; and be it further

RESOLVED, That our AMA work with the ABMS and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.

401. ADAPTIVE DRIVING BEAM HEADLIGHTS

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 401 ADOPTED
See Policy H-15.990

ADAPTIVE DRIVING BEAM HEADLIGHTS

RESOLVED, That our American Medical Association encourage the National Highway Traffic Safety Administration to undertake the necessary rulemaking to integrate automated high-beam to low-beam headlight switching lamps into the Federal Motor Vehicle Safety Standards.

402. SCHOOLS AS GUN-FREE ZONES
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-145.983

RESOLVED, That our American Medical Association advocate for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and be it further

RESOLVED, That our AMA oppose requirements or incentives of teachers to carry weapons.

403. SCHOOL SAFETY AND MENTAL HEALTH
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY H-345.977 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association promote the implementation of school-based mental health screening and therapy programs within its efforts to reduce school-based firearm violence.

404. EMPHASIZING THE HUMAN PAPILLOMAVIRUS VACCINES AS ANTI-CANCER PROPHYLAXIS FOR A GENDER-NEUTRAL DEMOGRAPHIC
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY D-170.995 AMENDED IN LIEU OF RESOLUTION 404

Policy D-170.995 amended by addition and deletion to read as follows:

> Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in ~~both males and females~~ all genders, the causal relationship of HPV to cancer and genital lesions ~~and cancer cervical~~, and the importance of routine pap tests ~~smears~~ in the early detection of ~~cervical~~ cancer; (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine; and (3) support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.

405. RACIAL HOUSING SEGREGATION AS A DETERMINANT OF HEALTH AND PUBLIC ACCESS TO GEOGRAPHIC INFORMATION SYSTEMS (GIS) DATA
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-350.953

RESOLVED, That our American Medical Association oppose policies that enable racial housing segregation; and be it further

RESOLVED, That our AMA advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education,

and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.

406. SUPPORT FOR PUBLIC HEALTH VIOLENCE PREVENTION PROGRAMS
Introduced by Medical Student Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-10.982, H-515.964, H-515.971 AND H-515.979 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support legislation in addition to other mechanisms that encourage the development and use of evidence-based public health models that prevent violence.

407. SUPPORT FOR RESEARCH OF BOXES FOR BABIES' SLEEPING ENVIRONMENT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-245.977

RESOLVED, That our American Medical Association encourage further research of infant safe sleeping environment programs, including, but not limited to, the study of the safety and efficacy of boxes.

408. ENDING MONEY BAIL TO DECREASE BURDEN ON LOWER INCOME COMMUNITIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-80.993

RESOLVED, That our American Medical Association (1) recognize the adverse health effects of pretrial detention; and (2) support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

409. FOOD ADVERTISING TARGETED TO YOUTH
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-60.972

RESOLVED, That our American Medical Association establish a formal position advocating against the use of targeted marketing of nutrient-poor food toward youth from vulnerable populations, including minority and low-income populations; and be it further

RESOLVED, That our AMA amend Policy H-60.972 by addition to read as follows:

(1) It is the policy of ~~the~~ our AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children; and

(2) Our AMA will support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA, when such marketing targets youth, especially vulnerable populations.

and be it further

RESOLVED, That our AMA work with the appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward youth from vulnerable populations.

410. OPPOSITION TO MEASURES THAT CRIMINALIZE HOMELESSNESS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association oppose measures that criminalize necessary means of living among homeless persons, including but not limited to, sitting or sleeping in public spaces; and be it further

RESOLVED, That our AMA advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights.

411. REPORTING CHILD ABUSE IN MILITARY FAMILIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-515.960

RESOLVED, That our American Medical Association support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.

412. REDUCING THE USE OF RESTRICTIVE HOUSING IN PRISONERS WITH MENTAL ILLNESS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-430.983

RESOLVED, That our American Medical Association support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; and be it further

RESOLVED, that our AMA support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and be it further

RESOLVED, That our AMA encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.

413. IMPROVING SAFETY AND HEALTH CODE COMPLIANCE IN SCHOOL FACILITIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support the development and implementation of standardized, comprehensive guidelines for school safety and health code compliance inspections; and be it further

RESOLVED, That our AMA support policies aiding schools in meeting said guidelines, including support for financial and personnel-based aid for schools based in vulnerable neighborhoods; and be it further

RESOLVED, That our AMA support creation of a streamlined reporting system for school facility health data potentially through application of current health infrastructure.

414. SEX EDUCATION MATERIALS FOR STUDENTS WITH LIMITED ENGLISH PROFICIENCY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-170.968

RESOLVED, That our American Medical Association amend Policy H-170.968 by addition to read as follows:

H-170.968, Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools
(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; and <u>(h) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils</u>;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and (10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

415. REDUCING GUN VIOLENCE IN AMERICA
Introduced by Colorado

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-145.975, H-145.997, D-145.995 AND D-145.999 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm Policies D-145.995, "Gun Violence as a Public Health Crisis," H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," and H-145.997, "Firearms as a Public Health Problem in the United States - Injuries and Death"; and be it further

RESOLVED, That our AMA work with other physician organizations to actively lobby for restoration of funding for gun violence research at the Centers for Disease Control and Prevention and elsewhere; and be it further

RESOLVED, That our AMA review the Rand report on gun violence and other credible sources of research on causes and effective policy to reduce gun violence and report back at the 2018 Interim Meeting with findings and recommendations for further advocacy to reduce gun violence in the US.

416. MEDICAL RESPITE CARE FOR HOMELESS ADULTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-160.903

RESOLVED, That our American Medical Association encourage the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

417. REDUCING DISPARITIES IN OBSTETRIC OUTCOMES, MATERNAL MORBIDITY, AND PRENATAL CARE
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-420.993

RESOLVED, That our American Medical Association work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

418. A GUIDE FOR BEST HEALTH PRACTICES FOR SENIORS LIVING IN RETIREMENT COMMUNITIES
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-25.987

RESOLVED, That our American Medical Association, in collaboration with other interested parties, such as the public health community, geriatric specialties, and organizations working to advocate for seniors, create a repository of available resources for physicians to guide healthy practices for seniors who reside in independent living communities.

419. VIOLENCE PREVENTION
Introduced by Washington

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: FIRST AND THIRD RESOLVES REFERRED FOR REPORT AT THE 2018 INTERIM MEETING
SECOND RESOLVE NOT ADOPTED

RESOLVED, That our American Medical Association advocate that a valid permit be required before the sale of all rapidly-firing semi-automatic firearms; and be it further

RESOLVED, That our AMA study options for removing access to firearms for those who may be a threat to themselves or others; and be it further

RESOLVED, That our AMA study options for improving the mental health reporting systems and patient privacy laws at both the state and federal levels and how those can be modified to allow greater information sharing between state and federal government, law enforcement, schools and mental health professionals to identify, track and share information about mentally ill persons with high risk of violence and either report to law enforcement and/or the National Instant Criminal Background Check System, with appropriate protections.

420. MANDATORY INFLUENZA VACCINATION POLICIES FOR HEALTHCARE WORKERS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association enact as policy that no health care worker should be terminated from employment due solely to their refusal to be vaccinated for influenza.

421. PRODUCT DATE LABELS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-150.926

RESOLVED, That our American Medical Association support federal standardization of date labels on food products to ensure that the labels address safety concerns.

422. SCHOOL DRINKING WATER QUALITY TESTING, MONITORING, AND MAINTENANCE
Introduced by Michigan

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY H-135.928 AMENDED IN LIEU OF RESOLUTION 422

Policy H-135.928 amended by addition and deletion to read as follows:

Safe Drinking Water
Our AMA supports updates to the U.S. Environmental Protection Agency's Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by: (1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water; (2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations; (3) Informing consumers about the health-risks of partial lead service line replacement; (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems; (5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers; (~~5~~6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health; (~~6~~7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations; (~~7~~8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead; and (~~8~~9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act~~.~~; (10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.

423. GRILL BRUSH WARNING
Introduced by Michigan

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy D-10.991

RESOLVED, That our American Medical Association request that the appropriate federal agency require the placement of a warning label on all wire-bristle grill brushes informing consumers about the possibility of wire bristles breaking off and being accidentally ingested.

424. RAPE AND SEXUAL ABUSE ON COLLEGE CAMPUSES
Introduced by Michigan

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-515.956

RESOLVED, That our American Medical Association work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and be it further

RESOLVED, That our AMA strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.

425. HOSPITAL FOOD LABELING
Introduced by Washington

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-150.949

RESOLVED, That our AMA modify Policy H-150.949 by addition and deletion to read as follows:

H-150.949, Healthy Food Options in Hospitals
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises.
2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy ~~healthful~~ food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy ~~healthful~~ beverages.
3. Our AMA hereby calls for hospital cafeterias and inpatient meal menus to publish nutrition information.

426. DECREASE ADOLESCENT MORTALITY THROUGH MORE COMPREHENSIVE GRADUATED DRIVER LICENSING PROGRAMS
Introduced by Maryland

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-15.990

RESOLVED, That our American Medical Association support more comprehensive Graduated Driver Licensing programs including but not limited to more stringent permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions.

427. SUPPORT GUN BUYBACK PROGRAMS IN ORDER TO REDUCE THE NUMBER OF CIRCULATING UNWANTED FIREARMS
Introduced by Maryland

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-145.985

RESOLVED, That our American Medical Association support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

428. LGBTQIA+ INCLUSIVE SEX EDUCATION ALONGSIDE HETEROSEXUAL SEX EDUCATION
Introduced by Maryland

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY H-170.968 AMENDED IN LIEU OF RESOLUTION 428

Policy H-170.968 amended by addition and deletion to read as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools
Our AMA:
(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (~~g~~ h) are part of an overall health education program;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting

healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits;
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

429. E-CIGARETTE INGREDIENTS

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

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-495.973

RESOLVED, That our American Medical Association urge federal officials, including but not limited to the U.S. Food and Drug Administration (FDA), to prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and be it further

RESOLVED, That our AMA urge federal officials, including but not limited to the FDA, to require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

430. VECTOR-BORNE DISEASES

Introduced by American Academy of Dermatology, Florida, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology, American Society of Dermatopathology, California, Arizona, Mississippi, New Jersey, Maryland, South Carolina, Tennessee, Virginia, District of Columbia, New York, Michigan, Delaware, American Academy of Neurology, Georgia, Alabama, North Carolina, Massachusetts, Wisconsin, West Virginia. American College of Mohs Surgery

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: THIRD RESOLVE ADOPTED
FIRST AND SECOND RESOLVES REFERRED
See Policy H-440.820

RESOLVED, That our American Medical Association study the emerging epidemic of vector-borne diseases including an analysis of currently available testing and treatment standards and their effectiveness; and be it further

RESOLVED, That our AMA issue a white paper on vector-borne diseases for the purpose of increasing awareness of the epidemic of vector-borne diseases; and be it further

RESOLVED, That our AMA advocate for local, state and national research, education, reporting and tracking on vector-borne diseases.

431. LOW NICOTINE CIGARETTE PRODUCT STANDARD
Introduced by American Thoracic Society, American College of Chest Physicians

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association develop a report on the individual health and public health implications of a low nicotine standard for cigarettes. Such a report should consider and make recommendations on scientific criteria for selection of a nicotine standard that is non-addictive, regulatory strategies to ensure compliance with an established standard, how a low-nicotine standard should work with other nicotine products in a well-regulated nicotine market.

432. LEGAL ACTION TO COMPEL FDA TO REGULATE E-CIGARETTES
Introduced by American Thoracic Society, American College of Chest Physicians

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy D-495.992

RESOLVED, That our American Medical Association consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.

433. FIREARM SAFETY
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-145.993 and H-145.996

RESOLVED, That our American Medical Association adopt the following firearm safety policies:

1. Amend Policy H-145.993, "Restriction of Assault Weapons," by addition to read as follows:

   Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the public of all assault-type weapons, bump stocks and related devices, high capacity magazines, and armor piercing bullets.

2. Require the licensing of owners of firearms including completion of a required safety course and registration of all firearms.

3. Support local law enforcement in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding "concealed carry", by supporting "gun violence restraining orders" for

individuals arrested or convicted of domestic violence or stalking, and by supporting "red-flag" laws for individuals who have demonstrated significant signs of potential violence. In supporting local law enforcement, we support as well as the importance of "due process" so that decisions could be reversible by individuals petitioning in court for their rights to be restored.

434. HEALTH CARE WORKPLACE ERGONOMICS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-365.977

RESOLVED, That our American Medical Association: (1) support research on reducing physician and staff ergonomic injuries in the health care workplace, including but not limited to studying medical instrument and work station design and development; and (2) work with resident training programs, hospitals and other interested parties to help integrate evidence-based ergonomics programs with other types of wellness programs for physicians and medical staffs; and be it further

RESOLVED, That our AMA advocate for legislation that would: (1) appropriate an adequate percentage of research dollars to National Institutes of Health (NIH), NIH Institutes, National Science Foundation (NSF), The National Institute for Occupational Safety and Health (NIOSH), and National Academy of Medicine for basic and advanced research of health care workplace ergonomics; and (2) require that such research be focused on practicing physicians, with practicing physicians as Principal Investigators.

501. SYNTHETIC CANNABINOIDS
Introduced by American Society of Addiction Medicine

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-95.940 AND D-95.970 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association recognize that synthetic cannabinoids such as JWH-018, JWH-210, and other compounds sold by "street" names such as "Spice" and "K2", are potent agonists in the mammalian endocannabinoid system and are dangerous when smoked or consumed; and be it further

RESOLVED, That our AMA advocate that the Schedule I status of synthetic cannabinoids under the federal Controlled Substances Act should be retained since these compounds are "drugs with no currently accepted medical use and a high potential for abuse"; and be it further

RESOLVED, That our AMA advocate that in any state or other jurisdiction in the U.S. considering changes in the legal status of cannabis, those changes should make explicitly clear that synthetic cannabinoids are unsafe and unfit for human consumption and their possession, use, sale and distribution by persons of all ages should remain illegal.

502. EXPEDITED PRESCRIPTION CANNABIDIOL (CBD) DRUG RESCHEDULING
Introduced by Colorado, Mississippi, Oregon

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTION 509
TITLE CHANGED
See Policy H-120.926

RESOLVED, That our American Medical Association encourage state controlled substance authorities, boards of pharmacy, and legislative bodies to take the necessary steps including regulation and legislation to reschedule U.S. Food and Drug Administration (FDA)-approved cannabidiol products, or make any other necessary regulatory or legislative change, as expeditiously as possible so that they will be available to patients immediately after approval by the FDA and rescheduling by the U.S. Drug Enforcement Administration; and be it further

RESOLVED, That our AMA advocate that an FDA-approved cannabidiol medication should be governed only by the federal and state regulatory provisions that apply to other prescription-only products, such as dispensing through pharmacies, rather than by these various state laws applicable to unapproved cannabis products.

503. ADVOCATING FOR ANONYMOUS REPORTING OF OVERDOSES BY FIRST RESPONDERS AND EMERGENCY PHYSICIANS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICY H-95.940 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support non-fatal and fatal opioid overdose reporting to the appropriate agencies.

504. ENDING THE RISK EVALUATION AND MITIGATION STRATEGY (REMS) POLICY ON MIFEPRISTONE (MIFEPREX)
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy H-100.948

RESOLVED, That our American Medical Association support efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.

505. RESEARCHING DRUG FACILITATED SEXUAL ASSAULT TESTING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association study the feasibility and implications of offering drug testing at point of care for date rape drugs, including rohypnol, ketamine, and gamma-hydroxybutyrate, in cases of suspected non-consensual, drug-facilitated sexual assault.

506. NON-THERAPEUTIC GENE THERAPIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED FOR DECISION FOLLOWING RECONSIDERATION

RESOLVED, That our American Medical Association partner with relevant institutions to encourage the development of safety guidelines, regulations, and permissible uses of performance enhancing, non-therapeutic gene therapies.

PRIOR TO REFERRAL, THE PROPOSAL HAD BEEN AMENDED TO READ:

RESOLVED, That our American Medical Association encourages the development of safety guidelines and regulations regarding performance enhancing, non-therapeutic gene therapies.

507. OPIOID TREATMENT PROGRAMS REPORTING TO PRESCRIPTION MONITORING PROGRAMS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association amend Policy D-95.980, "Opioid Treatment and Prescription Drug Monitoring Programs," by deletion as follows:

Our AMA will seek changes to ~~allow states the flexibility to~~ require opioid treatment programs to report to prescription monitoring programs.

508. MITOCHONDRIAL DONATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
TITLE CHANGED
See Policy H-480.942

RESOLVED, That our American Medical Association support regulated research to determine the efficacy and safety of mitochondrial donation as a means of preventing the transmission of mitochondrial diseases.

509. OPPOSING THE CLASSIFICATION OF CANNABIDIOL AS A SCHEDULE 1 DRUG
Introduced by Medical Student Section

Resolution 509 was considered with Resolution 502. See Resolution 502.

RESOLVED, That our American Medical Association support the reclassification of Cannabidiol as a non-scheduled drug.

510. ALCOHOL USE AND CANCER
Introduced by American Society of Clinical Oncology

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-30.937 AND H-30.942 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association recognize alcohol use as a modifiable risk factor for cancer; and be it further

RESOLVED, That our AMA support research and educational efforts about the connection between alcohol use and several types of cancer; and be it further

RESOLVED, That our AMA encourage physicians to counsel patients on the risks of alcohol use and cancer.

511. EDUCATION FOR RECOVERING PATIENTS ON OPIATE USE AFTER SOBRIETY
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-95.987

RESOLVED, That our AMA amend Policy D-95.987 by addition to read as follows:

D-95.987, Prevention of Opioid Overdose
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

3. Our AMA supports the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

512. PHYSICIAN AND PATIENT EDUCATION ABOUT THE RISK OF SYNTHETIC CANNABINOID USE
Introduced by Illinois

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICIES H-95.940 AND D-95.970 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage all physicians to become aware of the adverse psychiatric and medical effects, including coagulopathy with severe bleeding, related to the use of synthetic cannabinoids, which may or may not be contaminated; and be it further

RESOLVED, That our AMA encourage physicians to educate their patients about synthetic cannabinoids and strongly advise them that the use of these drugs carries significant health risks that can produce psychiatric morbidity and hematological mortality.

513. HAND SANITIZER EFFECTIVENESS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association urge the U.S. Food and Drug Administration and the Centers for Disease Control and Prevention to continue to study the use of hand sanitizers in clinical settings, including the risks and benefits to patients and health care professionals.

514. EFFECTS OF VIRTUAL REALITY ON HUMAN HEALTH
Introduced by

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy H-478.982

RESOLVED, That our American Medical Association support further study on the impact of virtual reality on human health.

515. INFORMATION REGARDING ANIMAL-DERIVED MEDICATIONS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support efforts to improve cultural awareness pertaining to the use of animal-derived medications when considering different prescription options; and be it further

RESOLVED, That our AMA encourage the U.S. Food and Drug Administration to make available to the public an easily accessible database that identifies medications containing ingredients derived from animals.

516. WASTE INCINERATOR BAN
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-135.939

RESOLVED, That our American Medical Association amend Policy H-135.939 by addition to read as follows:

H-135.939, Green Initiatives and the Health Care Community
Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic,

sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

517. IMPACT OF NATURAL DISASTERS ON PHARMACEUTICAL SUPPLY AND PUBLIC HEALTH
Introduced by Michigan

Resolution 517 was considered with Council on Science and Public Health Report 2.
See Council on Science and Public Health Report 2.

RESOLVED, That our American Medical Association study the impact of natural disasters on the pharmaceutical supply chain and downstream effects on patient care, as well as the adequacy of our governmental response to mitigating these recent natural disasters; and be it further

RESOLVED, That our American Medical Association amend policy H-100.956 by addition to read as follows:

H-100.956, National Drug Shortages
1. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that experience drug shortages, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
2. Our AMA supports authorizing the Secretary of Health and Human Services to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
3. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
4. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
5. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The Centers for Medicare & Medicaid Services should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.
6. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
7. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
8. Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
9. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.

518. PORTABLE LISTENING DEVICES AND NOISE INDUCED HEARING LOSS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICY H-440.957 AMENDED IN LIEU OF RESOLUTION 518

Policy H-440.957 amended by addition and deletion to read as follows:

Reporting Potential for Hearing Loss Due to Personal Listening Devices
It is the policy of the AMA that (1) physicians counsel patients about the potential loss of hearing associated with the misuse of personal listening devices; (2) research be directed at more specific definition of the relationship between acute and chronic use of personal listening devices and the occurrence of short-term and long-term noise-induced hearing loss; ~~and~~ (3) the AMA work with the National Institute on Deafness and Other Communication Disorders to enhance awareness, knowledge and remediation of causes of noise induced hearing loss~~.~~; and (4) portable listening devices limit the maximum sound amplitude to safe levels.

519. WARNING LABELS FOR CHILDREN'S DIGITAL AND VIDEO GAMES
Introduced by Maryland

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-60.911, H-60.915 AND H-515.974 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for putting warning labels on digital and video games, warning parents to monitor children's use and be aware that for some children this can become habit forming, leading to increased time spent on gaming at the cost of more important developmental issues, take precedence over other aspects of their life and escalate despite the occurrence of negative consequences and withdrawal symptoms may occur when attempts are made to reduce or stop it.

520. HANDLING OF HAZARDOUS DRUGS
Introduced by American Urological Association, American Association of Clinical Urologists, American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Society of Dermatopathology, Society for Investigative Dermatology

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-120.930, H-330.884 AND D-120.941 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with United States Pharmacopeia to revisit the requirements in General Chapter <800> of the USP Compounding Compendium and review Chapters <795> and <797> to ensure that the requirements included in those chapters are not onerous to physicians and prohibitive to their current ability to provide medications to their patients.

521. EPA GILDER TRUCK STANDARD
Introduced by American Thoracic Society, American College of Chest Physicians

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
POLICY D-135.996 AMENDED
See Policy D-135.996

RESOLVED, That our American Medical Association send a letter to U.S. Environmental Protection Agency (EPA) Administrator opposing the EPA's proposal to roll back the "Glider Kit Rule" which would effectively allow the unlimited sale of reconditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.

Policy D-135.996 amended by addition and deletion to read as follows:

Reducing Sources of Diesel Exhaust
Our AMA will:
(1) encourage the US Environmental Protection Agency to set and enforce ~~finalize~~ the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains;
(2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; and
(3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current ~~new~~ diesel emissions standards promulgated by US EPA.

522. SILENCE SCIENCE: EPA PROPOSED DATA POLICY
Introduced by American Thoracic Society, American College of Chest Physicians

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association submit comments during the public comment period, or join comments written by other medical organizations, to express concern with the U.S. Environmental Protection Agency's (EPA) proposal to limit the use of research studies published in peer reviewed scientific journals that describe the adverse health effects of exposure to air pollution and other environmental exposures; and be it further

RESOLVED, That our AMA reaffirm the value and integrity of the journal peer review process by sending a letter to the EPA stating that studies that have been published in scientific peer reviewed journals should be used by the agency in informing EPA regulatory policy making.

523. BIOSIMILAR INTERCHANGEABILITY PATHWAY
Introduced by American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, American Academy of Neurology, American Academy of Ophthalmology, American Association of Clinical Endocrinologists, American Gastroenterological Association, American Society of Clinical Oncology, American Society of Hematology, American College of Allergy, Asthma and Immunology

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-125.976

RESOLVED, That our American Medical Association strongly support the pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug; and be it further

RESOLVED, That our AMA issue a request to the FDA that the agency finalize the biosimilars interchangeability pathway outlined in its draft guidance "Considerations in Demonstrating Interchangeability With a Reference Product" with all due haste, so as to allow development and designation of interchangeable biosimilars to proceed, allowing transition to an era of less expensive biologics that provide safe, effective, and accessible treatment options for patients.

524. NALOXONE ON COMMERCIAL AIRLINES
Introduced by Arizona

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy H-45.981

RESOLVED, That our American Medical Association support the addition of naloxone to the airline medical kit; and be it further

RESOLVED, That our AMA encourage airlines to voluntarily include naloxone in their airline medical kits; and be it further

RESOLVED, That our AMA encourage the addition of naloxone to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).

525. TRAMADOL CHANGE FROM DEA SCHEDULE IV TO SCHEDULE III
Introduced by Arizona

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association petition the United States Drug Enforcement Administration to change tramadol from a Schedule IV to a Schedule III controlled substance.

526. DIRECT-TO-CONSUMER LABORATORY TESTING
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy H-480.941

RESOLVED, That our American Medical Association: (1) advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2) encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.

601. CREATION OF LGBTQ HEALTH SPECIALTY SECTION COUNCIL
Introduced by GLMA: Health Professionals Advancing LGBT Equality

Reference committee hearing: see report of Reference Committee F

HOUSE ACTION: ADOPTED
See Policy D-615.978

RESOLVED, That our American Medical Association House of Delegates establish a Specialty Section Council on LGBTQ Health.

602. HEALTH FITNESS PARTNERSHIPS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-405.952

RESOLVED, That our American Medical Association promote evidence-based health and wellness programs among AMA members; and be it further

RESOLVED, That our AMA further investigate and explore relationships with health and fitness companies to promote evidence-based health and wellness programs among AMA members, including arrangements under which attractive discounts are offered to AMA members.

603. ELIMINATING FOOD WASTE THROUGH RECOVERY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy G-630.135

RESOLVED, That our American Medical Association consider sustainability and mitigation of food waste in vendor and venue selection; and be it further

RESOLVED, That our AMA encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donations.

604. AMA DELEGATION ENTITLEMENTS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association continue to provide a count of AMA members for AMA delegation entitlements to the House of Delegates as of December 31 and also provide a second count of AMA members within the first two weeks of the new year and that the higher of the two counts will be used for state and national specialty society delegation entitlements during the current year; and be it further

RESOLVED, That the Council on Constitution and Bylaws prepare appropriate language to add a second period of time to determine AMA delegation entitlements to be considered by the AMA House at its earliest opportunity.

605. PRACTICING PHYSICIAN DECLINING MEMBERSHIP ANALYSIS
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association release to its membership annually in its Annual Report any and all aggregate data for that year it has pertaining to reasons physicians are either leaving or not joining the AMA ("Data"), including but not limited to, survey data, focus group data, and exit interview data, giving specific attention to those physicians in the "Young," "Mature," and "Senior" membership categories.

606. TRAINING PHYSICIANS IN THE ART OF PUBLIC FORUM
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association establish a program for training physicians in the art and science of conducting public forums in order to ensure that the public is well informed on the health care system of our country.

607. DISCOUNTED / WAIVED CPT FEES AS AN AMA MEMBER BENEFIT AND FOR MEMBERSHIP PROMOTION
Introduced by Gregory L. Pinto, MD, Delegate

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED FOR REPORT AT THE 2019 ANNUAL MEETING

RESOLVED, That our American Medical Association investigate mechanisms by which AMA members may receive a discount or waiver on CPT-related fees, including fees associated with using CPT codes within electronic medical billing systems.

608. DIVESTMENT FROM COMPANIES WHOSE PRIMARY BUSINESS IS FOSSIL FUEL
Introduced by American Association of Public Health Physicians

Resolution 608 was considered with Board of Trustees Report 34. See Board of Trustees Report 34.

RESOLVED, That our American Medical Association, Foundation, and any affiliated corporations work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and be it further

RESOLVED, That our AMA, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and be it further

RESOLVED, That our AMA support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.

701. EMPLOYED PHYSICIANS BILL OF RIGHTS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee G

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association adopt an "Employed Physician's Bill of Rights"; and be it further

RESOLVED, That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational endeavors and preparation, committee participation, student/resident activities and administrative responsibilities; and be it further

RESOLVED, That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits; and be it further

RESOLVED, That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems; and be it further

RESOLVED, That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives; and be it further

RESOLVED, That this bill of rights include the principle that physician activities performed outside of defined employed-time boundaries are the sole prerogative of the individual physician and not the employer organization unless it directly conflicts with or increases risk to the organization; and be it further

RESOLVED, That this bill of rights include the principle that conflict-of-interest disclosures should be limited to physician activities that directly affect the organization and should only be disclosed to entities that directly reimburse the physician during their employed time period; and be it further

RESOLVED, That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians; and be it further

RESOLVED, That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines; and be it further

RESOLVED, That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act); and be it further

RESOLVED, That this bill of rights include the principle that all physicians be empowered to first be the patient's advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient's health care and dignity.

702. BASIC PRACTICE PROFESSIONAL STANDARDS OF PHYSICIAN EMPLOYMENT
Introduced by Indiana

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.
2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.
3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.
4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other "greater societal good" organizations.
5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region.

703. ECONOMIC CREDENTIALING
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICY H-180.963 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association vigorously oppose clinical credentialing based solely on surgical and non-surgical case volume when there is no other basis for questioning the physician's ability to function with skill and safety.

704. NON-PAYMENT AND AUDIT TAKEBACKS BY CMS
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association seek through legislation and/or regulation policies opposing claim nonpayment due to minor wording or clinically insignificant documentation inconsistencies; and be it further

RESOLVED, That our AMA seek through legislation and/or regulation policies opposing extrapolation of overpayments based on minor inconsistencies; and be it further

RESOLVED, That our AMA seek through legislation and/or regulation policies opposing bundled payment denial based on minor wording or clinically insignificant documentation inconsistencies.

705. MODIFY THE CLINICAL LABORATORY IMPROVEMENT AMENDMENT OF 1988
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association adopt the position that it is proper to remove the CLIA certification mandate requirement for physicians who only use CLIA-waived tests and physician-performed microscopy.

706. ENSURING MEDICARE COVERAGE FOR LONG TERM CARE
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-280.985

RESOLVED, That our AMA work to identify additional mechanisms by which patients' out-of-pocket costs for skilled nursing facility care can be fairly covered.

707. HEALTH PLAN PAYMENT OF PATIENT COST-SHARING
Introduced by California

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association urge health plans and insurers to bear the responsibility of ensuring physicians promptly receive full payment for patient copayments, coinsurance and deductibles.

708. ARBITRARY PAPERWORK AND SIGNATURE DEADLINES FOR HOSPITAL AND REHABILITATION UNIT ADMISSION
Introduced by Ohio

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES D-160.987 AND D-330.919 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work to change admission order signature timeframe regulations at the Centers for Medicare and Medicaid Services to be consistent with timeframe regulations for other verbal and telephone orders.

709. PRIOR AUTHORIZATION FOR DURABLE MEDICAL EQUIPMENT
Introduced by Ohio

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-285.998, H-320.942, H-320.968, H-320.939 AND H-330.955 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate that denials of prior authorization for durable medical equipment must be based on true medical necessity not arbitrary time limits or other paperwork issues; and be it further

RESOLVED, That our AMA continue to work to improve the prior authorization process for Medicare Managed Care Plans.

710. CODE STATUS THROUGH THE CONTINUUM OF CARE
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-140.955

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to streamline transfer of code status across the continuum of care.

711. COMPENSATION FOR PRE-AUTHORIZATION REQUESTS
Introduced by Ohio

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 petition the Centers for Medicare and Medicaid Services that CPT code 99080 be reimbursed by Medicare.

712. ALTERNATIVE PAYMENT MODELS AND VULNERABLE POPULATIONS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED That our American Medical Association study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and be it further

RESOLVED That our AMA advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

713. CORPORATE INVESTORS
Introduced by American Academy of Dermatology. American Society for Dermatologic Surgery Association, American Society of Dermatopathology, Society for Investigative Dermatology, American Society of Anesthesiologists, American College of Cardiology, American Roentgen Ray Society, American Academy of Ophthalmology, District of Columbia, American College of Mohs Surgery

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policies H-215.981 and D-383.979

RESOLVED, That our American Medical Association study, with report back at the 2019 Annual Meeting, the effects on the healthcare marketplace of corporate investors (eg, public companies, venture capital / private equity firms, insurance companies and hospital systems) acquiring a majority and / or controlling interest in entities that manage physician practices, such as:

- the degree of corporate investor penetration and investment in the healthcare marketplace;
- the impact on physician practice and independence;
- patient access;
- resultant trends in the use non-physician extenders;
- long term financial viability of purchased practices;
- effects of ownership turnovers and bankruptcies on patients and practice patterns;
- effectiveness of methodologies employed by unpurchased private independent, small group and large group practices to compete for insurance contracts in consolidated marketplaces;
- and the relative impact corporate investor transactions have on the paths and durations of junior, mid-career and senior physicians; and be it further

RESOLVED, That, in order to address the particular concerns of physicians entering into management service organization contracts, our American Medical Association amend the AMA Annotated Model Physician-Group Practice Employment Agreement (H-215.981) to read:

> "(2) At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations."

714. LABORATORY BENEFIT MANAGERS

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING ALTERNATIVE RESOLUTION 714 ADOPTED
See Policy H-260.962

RESOLVED, That our American Medical Association support efforts to reduce laboratory benefit management policies that result in delays in patient care, reduced patient access, or increased patient costs without clinical justification; and be it further

RESOLVED, That our AMA support that any policies regarding laboratory benefit management arrangements preclude any potential conflict of interest in programs adopted by health insurance payors to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management entity financially affiliated with a clinical laboratory.

715. THE OBLIGATORY NATURE AND ENDURING PURPOSE OF THE SELF-GOVERNED ORGANIZED MEDICAL STAFF
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-225.942

RESOLVED, That our American Medical Association amend Policy H-225.942 by addition to read as follows:

H-225.942, Physician and Medical Staff Member Bill of Rights

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This unparalleled accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:
   a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
   b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes.
   c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
   d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
   e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
   f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:
   a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent

legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.
c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:
   a. The responsibility to work collaboratively with other members and with the health care organization's administration to improve quality and safety.
   b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
   c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
   d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
   e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
   f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:
   a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
   b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
   c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body.
   d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
   e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
   f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

716. HOSPITAL CLOSURES AND PHYSICIAN CREDENTIALING
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the AMA Organized Medical Staff Section and National Association Medical Staff Services, to produce an AMA credentialing repository that would allow hospitals and other organizations that credential physicians to access verified credentialing information for physicians who were on staff at a hospital, or one of its departments, at the time of closure, and report back at the 2018 Interim Meeting.

717. IMPACT OF THE HIGH CAPITAL COST OF HOSPITAL EHRs ON THE MEDICAL STAFF
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-225.974

RESOLVED, That our American Medical Association study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to their impact on downsizing of medical staffs and its effect on physician recruitment and retention.