AMERICAN MEDICAL ASSOCIATION
ANNUAL MEETING ï CHICAGO 2019

CONSTITUTION AND BYLAWS

1. The American Academy of Sleep Medicine and the American Society of Cytopathology were given delegate status.
2. CEJA (Council on Ethical and Judicial Affairs) Report 1 discussed physician competence and self-assessment. It is important for physicians to practice informed self-assessment that leads to self awareness on their ability to practice safely. This report was referred back for further study.
3. CEJA Report discussed physician assisted suicide. It was determined that the term physician assisted suicide should be maintained rather than aid in dying. It was felt that the two terms have different ethical perspectives. CEJA opinion 5.7 was not changed which states that physician assisted suicide is fundamentally incompatible with a physicianôs role as healer. This report was approved.
4. A resolution asked the AMA to modify existing policy to support every individualôs right to determine their gender identity and sex determination on government documents.
5. The AMA was asked to encourage person centered language when discussing a disease state (e.g. ña person with schizophrenia rather than a schizophrenicò).
6. The AMA was asked to study all discrimination and harassment references in AMA policies.
7. The AMA should support guidelines for members of the Federation of Medicine and patient advocacy organizations to disclose donations, sponsorships and other financial transactions by industry and other commercial stakeholders.
8. The AMA should support legislation requiring investigations into the deaths of children in the foster care system.
9. The AMA should acknowledge that health care is a basic human right.
10. The AMA should adopt as policy that the distribution and display of human trafficking aid information should be allowed to be displayed in public places.
11. The AMA should recommend that physicians adopt the term ñintellectual disabilityò rather than ñmental retardationò.
12. The AMA should affirm that hospital medical staff bylaws should promote, and not impede, gender equity in their implementation.
13. The AMA through the Organized Medical Staff Section (OMSS) should educate medical students, physician in training and physicians entering into employment contracts with large organizations on the dangers of aggressive restrictive covenants.
14. The AMA should support physicians in assessing whether a minor has met maturity and medical decision making capacity requirements when providing consent for vaccinations.
15. The AMA should support changes in the Medicare guidelines to allow a physician to care for and receive reimbursement for immediate relatives of one of their colleagues in their practice.
16. The AMA should support the right of transgender or non binary individuals to seek gamete preservation therapies before undergoing gender affirming medical or surgical treatment. The AMA should support insurance coverage for gamete preservation in any

individual for whom a medical diagnosis or treatment modality could result in loss of fertility.

17. The AMA should advocate that a qualified physician, while retaining the ultimate responsibility for all aspects of the informed consent process, be able to delegate tasks associated with the process to other qualified members of the health care team.
18. The AMA should partner with other organizations to immediately increase efforts to educate the public, legislators and members of law enforcement using verified data related hate crimes against transgender individuals.
19. The AMA should support state policies allowing minors to override their parentôs refusal for vaccinations and encourage state legislatures to establish comprehensive vaccine and minor consent policies.
20. The AMA should recognize the need for ethical, transparent, and consistent body and body part donation regulations.
21. The AMA should advocate that health care services provided to minors in immigrant detention centers focus solely on the health and well being of the patient.
22. The AMA should oppose mandated reporting of individuals who question or express interest in exploring their gender identity.
23. The AMA should advocate for collection of patient data in medical documentation and medical research studies, according to best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits such as differences and disorders of sex development.

REFERENCE COMMITTEE A ï MEDICAL SERVICE

1. Council on Medical Service (CMS) Report 2 discussed covering the uninsured. The report recommends that the AMA support removing the subsidy ñcliffsò thereby expanding eligibility for premium tax credits beyond 400% of the federal poverty level, support increasing the generosity of premium tax credits, support expanding eligibility for cost sharing reductions and support increasing the size of cost sharing reductions. The recommendations were to improve the ACA. There was discussion as to changing the AMAôs opposition to single payer but that was defeated.
2. CMS Report 3 recommends that the AMA reaffirm policy supporting continued opportunities to work with the American Dental Association to improve access to dental care for Medicare beneficiaries.
3. CMS Report 5 recommends that the AMA support the active regulation of pharmacy benefit managers under state departments of insurance.
4. CMS Report 6 recommends that the AMA encourage public and private payers to ensure coverage for prostate cancer screening when the service is deemed appropriate.
5. A resolution was adopted that the AMA adopt policy that the use of a health savings account (HSA) for access to primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense , and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care.

6. CMS Report 4 recommends that the AMA support the reclassification of complex rehabilitation technology (CRT) as a separate, distinct and adequately funded payment category to improve access to the most appropriate and necessary equipment.
7. The AMA should support health plans and PBMs providing a process for expedited formulary exceptions in the event of a recall of a generic medication, to ensure patient access to the brand medication or an affordable alternative.
8. The AMA should support a US Government Accountability Office (GAO) study of Medicare Part D plan risk assessment behaviors and strategies and their impact on direct subsidy, reinsurance subsidy and risk corridor payments.
9. A resolution passed that the AMA support the personal importation of prescription drugs only if: (a) patient safety can be assured, (b) product quality, authenticity and integrity can be assured, (c) prescription drug products are subject to reliable, ñelectronicò track and trace technology, and (d) prescription drug products are obtained from a licensed foreign pharmacy.
10. The AMA should work with appropriate stakeholders to include coverage for all US FDA approved contraceptive methods for contraceptive and non contraceptive use.
11. The AMA should support policy to remove liquid oxygen from the competitive system and return payments for liquid oxygen to a Medicare fee schedule basis.
12. The AMA should work with payers to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians.
13. The AMA should support the availability of over the counter hearing aids for the treatment of mild to moderate hearing loss.
14. AMA Policy H-110.991 ñPrice of Medicineò was modified such that the AMA should work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out of pocket costs for prescription medications sold at both retail and mail order/online pharmacies.
15. A resolution was passed that the AMA work for enactment of legislation to direct cash payments from Medicare Part A to physicians in direct proportion to demonstrated savings that are made in Part A Medicare through the efforts of physicians.
16. A resolution was passed that the AMA support coverage and reimbursement for evidence based treatment of Autism Spectrum Disorder including, but not limited to Applied Behavior Analysis Therapy.
17. A resolution asked that the AMA request that the Centers for Medicare and Medicaid Services (CMS) terminate the ñ48 hour observation periodò and observation status in total.

REFERENCE COMMITTEE B ï LEGISLATION

1. BOT Report 14 reaffirmed policy which outlines a series of measures to address self competitive actions by pharmaceutical manufacturers as well as promote increased price transparency. The AMA should support legislation to shorten the exclusivity

period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors.

2. BOT Report 23 asked that the advocate for removal of barriers to non opioid pain care. The AMA should support amendments to opioid restriction policies to allow for exceptions that enable physicians when medically necessary to exceed statutory, regulatory or other thresholds for post operative pain care. The AMA should oppose utilization management policies, including prior authorization, that restrict access to post operative pain care.
3. BOT Report 30 supports state flexibility to determine whether state Opioid Treatment Programs should be required to report to state prescription monitoring programs.
4. The AMA should oppose the practice of a payer imposing financial penalties upon patients or physicians based upon the use of statistical targets without first considering the clinical features of the case.
5. The AMS should support the streamlining of the SNOMED categories for smoking status and passive smoking exposure documentation in the electronic medical record.
6. The AMA was asked to research the problems related to the handling of sex and gender within health information technology products and how to best work with vendors so that HIT products treat patients equally and appropriately, regardless of sexual or gender identity.
7. The AMA should advocate at the state and national levels to promote Prescription Drug Monitoring Programs (PDMP) integration/access within electronic health record workflows at no cost to the physician.
8. BOT Report 17 asked the AMA to urge Medicare Advantage (MA) Plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period. MA plans should be required to immediately remove from provider directories providers who no longer practice in the network. The AMA should urge CMS to ban ñno cause: terminations of MA network physicians during the initial term or any subsequent renewal term of a physicianôs participation contract.
9. BOT Report 18 recommended that law enforcement policies governing the use of body worn cameras in health care settings be developed and evaluated with input from physicians and not interfere with the patient-physician relationship.
10. BOT Report 20 amended existing policy regarding electronic prescriptions. It was encouraged that there should be support for the electronic transfer and cancellation of prescriptions.
11. BOT Report 21 discussed augmented intelligence. It was stated that AI systems for clinical care must be conditioned on (a) clinical validation, (b) alignment with clinical decision making that is familiar to physicians, and (c) high quality clinical evidence. AI is designed to human intelligence and the patient-physician relationship rather than replace it.
12. BOT Report 22 stated that the AMA should support balanced opioid sparing policies that are not based on hard thresholds, but on patient individuality. The AMA should incorporate into its advocacy that clinical practice guidelines specific to cancer treatment, palliative care, and end of life be utilized in lieu of the CDCôs Guideline for Prescribing Opioids for Chronic Pain.
13. The AMA should work with professional and patient centered organizations to advance patient and physician directed coordinated care for End Stage Renal Disease

(ESRD) patients. The AMA should oppose any legislative of regulatory efforts to remove patient choice and physician involvement in ESRD care decisions. The AMA should actively oppose any effort that would create financial incentives that would curtail the access to kidney transplantation.

14. The AMA should advocate that any monies paid to states, received as a result of a settlement or judgment as a result of litigation against pharmaceutical manufacturers, distributors, or other entities alleged to have engaged in unethical and deceptive misbranding or marketing of opioids be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain.
15. The AMA should support modification of the Sunshine Act, such as substantially increasing the monetary threshold for reporting.
16. The AMA should advocate that the AMA advocate that any legislation addressing surprise out of network medical bills use an independent, non conflicted data base of commercial charges.
17. The AMA should advocate that medications and other treatments used to stabilize palliative and hospice patients in the hospital be covered after patients are transitioned out of the hospital.
18. The AMA should affirm that the term physician be limited to people who have a Doctor of Medicine, Doctor of Osteopathic Medicine or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
19. The AMA should advocate that a physicianôs office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay.
20. The AMA should advocate for increased access and coverage of non-opioid treatment modalities recommended by the patientôs physician.
21. The AMA should support the alignment of federal privacy laws and regulations with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state law for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use substance use disorder records in criminal proceedings.
22. The AMA should work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.
23. The AMA should oppose the misappropriation of medical specialtiesô titles and work with state societies to advocate for state and administrative agencies overseeing non physician providers to authorize only the use of titles and descriptors that align with the providerôs state issued license. Truth in Advertising.
24. The AMA should support funding for the National Heart, Lung and Blood Institute and the CDC, for the purpose of implementing the COPD National Action Plan.
25. The AMA should advocate to CMS to adopt the concept of ñcap flexibilityò and allow new and current Graduate Medical Education teaching institutions to extend their cap building window for up to an additional five years giving priority to new residence programs in underserved areas.
26. The AMA should work with public or private sector standard setting organizations to create standards for the development and implementation of blockchain technologies in health care. Block chain is a distributed database that stores records of all

transactions and digital events performed by its participants. It is felt that blockchain technology my help drive transparency, data integrity, and authenticity.

27. The AMA, in an effort to advance the feasibility of population health research to fulfill the promise of value based care, will request that CMS eliminate the prohibitions on sharing data outside of any CMS model including Accountable Care Organizations.
28. The AMA should oppose the reduction to military GME residency or fellowship programs without dedicated congressional funding for an equal number of civilian residency positions.

REFERENCE COMMITTEE C ï MEDICAL EDUCATION

1. BOT Report amended policy to make an addition that the AMA encourages the Secretary of the U,S, Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems and health centers with residency programs are utilizing these financial services to meet the nationôs health care needs.
2. Council on Medical Education (CME) Report 2 Said that the AMA through the council should continue to work with the ABMS and the ABMS Committee on Continuing Certification to pursue and implement recommendations of the Vision for the Future Commission.
3. The AMA will continue to work with and support the Federation of State Physician Health Programs (FSPHP) efforts already underway to design and implement the physician health program review process.
4. The AMA will promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community based primary care physicians.
5. The AMA should work with the ACGME to amend the ACGME Common Program Requirements to allow flexibility in the specialty specific ACGME program requirements enabling specialties to require salary reimbursement or ñprotected timeò for resident and fellow education by ñcore faculty:, program directors, and assistant/associate program directors.
6. The AMA encourages the resident matching services to reduce barriers to the match process including barriers to ñcouple matchingò.
7. CME Report 4 asked the AMA to encourage accrediting and licensing bodies to study how augmented intelligence should be most appropriately addressed. The AMA should encourage the study of how differences in institutional access to AI may impact disparities in education and also for patients in communities with fewer resources in AI technology.
8. The AMA should explore the viability and cost effectiveness of regularly collecting National Death Index data and confidentially maintain manner of death information for physicians, residents and medical students listed as deceased in the AMA Masterfile. The AMA should collaborate with other stakeholders to

study the incidence and risk factors for depression, substance abuse and addiction, and suicide among physicians, residents, and medical students.

9. The AMA should recommend that medical school policies on hazardous exposure include options to limit hazardous exposure in a manner that does not impact studentsô ability to successfully complete their training. Policies should also address continuity of educational requirements toward degree completion when a pregnant trainee wishes a leave of absence or temporary reassignment to minimize risks.
10. The AMA should support teaching on climate change in undergraduate, graduate, and continuing education.
11. The AMA should recognize and support that the environment for education of residents and fellows must be free of the conflict of interest created between a training siteôs fiduciary responsibility to shareholders and the educational mission of residency or fellowship training.
12. The AMA should support the publication of a white paper chronicling health care career pipelines across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals.
13. The AMA should study current standards within medical education regarding the clinical use of pathology and laboratory medicine information to identify potential gaps in training in the principles of decision and the utilization of quantitative evidence.
14. The AMA should oppose changes in residency and fellowship application requirements unless those changes have been evaluated by working groups which have students and residents as representatives.
15. The AMA should define resident and fellow scholarly activity as any rigorous, skill building experience approved by their program director.
16. The AMA should formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.
17. The AMA should work with relevant stakeholders to study available data on medical graduates with disabilities and challenges to employment after training.
18. The AMA should undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (including telehealth) to alleviate rural physician workforce shortages.
19. The AMA should work with the AAMC to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data to determine their effectiveness.
20. The AMA should encourage the AAMC and the American Association of Colleges of Osteopathic Medicine to support the study of factors surrounding leaves of absence and withdrawal from medical training.

REFERENCE COMMITTEE D ï PUBLIC HEALTH

1. BOT Report 11 reaffirmed policy that recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off. The report also encourages employers to offer and/or expand paid parental leave policies.
2. BOT Report 16 asked the AMA to help educate physicians regarding the unique healthcare and social needs of homeless patients on discharge from hospitals and emergency rooms.
3. BOT Report 28 supports laws protecting the civil and human rights of individuals experiencing homelessness.
4. Council and Science and Public Health (CSPH) Report 3 acknowledges that all tobacco products are harmful to health. Congress will be urges to pass legislation to phase in the production of reduced nicotine content tobacco products.
5. CSPH amended existing policy asking for improved surveillance for vector born diseases to better understand the geographic distribution of infectious vectors. Also the report asked for the development and funding of comprehensive and coordinated vector born disease prevention and control programs at the federal, state, and local level.
6. The AMA should support the disaggregation of data regarding the American and Pacific Islander initiative (AAPI) in order to reveal the AAPI ethnic subgroup disparities that exist in health care outcomes and also in representation in medicine, including but not limited to leadership in academic medicine. There should be a report at the annual meeting in 2020.
7. The AMA should monitor the development of autonomous vehicles, with particular focus on the technologyôs impact on motor vehicle related injury and death.
8. The AMA should make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with the CDC.
9. The AMA should work with the National Transportation Safety Board to support physician input on research into the capability of autonomous vehicles to enable individuals who are visually impaired or developmentally disables to benefit from autonomous vehicle technology.
10. BOT Report 29 supports the adoption of standards in schools that limit harmful substances from school facility environments, ensure safe drinking water and indoor air quality, and promote childhood environmental health and safety in an equitable manner.
11. The AMA should support the use of pregnancy intention screening as part of routine well care and recommend that it be documented in the electronic medical record.
12. The AMA supports sunshade screens (such as trees, awnings, gazebos, etc.) in the planning of public and private spaces in recognition of sun protection as a public health measure.

13. The AMA should advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a nonregistered user.
14. The AMA supports the reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer.
15. The AMA should work with the CDC to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.
16. The AMA supports and will advocate for the funding of plans to end the HIV epidemic.
17. The AMA will actively legislation to decrease distracted driving injuries and fatalities by banning the use of electronic communication while operating a motor vehicle.
18. The AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to eliminate non medical exemptions from mandated pediatric immunizations.
19. The AMA should collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
20. The AMA should work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards.
21. The AMA should support linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care.
22. The AMA supports an incarcerated personôs right to accessible comprehensive evidence based contraceptive education
23. The AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations.
24. The AMA will advocate that all correctional, detention and juvenile facilities be accredited.
25. The AMA supports legislation and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults.
26. The AMA should advocate for repeal of legislation that criminalizes the non disclosure of HIV status. The work with others to develop a program whose primary goal is to destigmatize HIV infection.
27. The AMA should develop an actionable advocacy plan to positively impact local, community based public health, including but not limited to the development of rural public health networks, training of current and future physicians in core public health techniques.

REFERENCE COMMITTEE E ï SCIENCE AND TECHNOLOGY

1. The AMA should use clinically accurate, non stigmatizing terminology (e,g., substance abuse disorder vs substance abuse or alcoholism) in all future resolutions, reports and educational materials.
2. The AMA should support screening for critical congenital heart defects for newborns following delivery prior to hospital discharge.
3. The AMA should support the implementation of childcare resources in existing substance use treatment facilities.
4. The AMA should support the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription. The AMA should support the widespread implementation of easily accessible naloxone rescue stations.
5. The AMA should support research on problematic pornography use.
6. The AMA should work with appropriate stakeholders to develop and disseminate educational materials aimed at dispelling the fear of bystander overdose via inhalation or dermal contact with fentanyl.
7. The AMA should continue its compounding working group, consisting of national specialty organizations, state medical societies, relevant agencies and other appropriate stakeholder to advocate for appropriate application of standards and to monitor policy impacting physicians.
8. The AMA should support comprehensive evidence based care, legislation, and initiatives that address the specific needs of children of incarcerated parents.
9. The AMA supports evidence based primary prevention strategies for Adverse Childhood Experiences (ACE). The AMA supports funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.
10. The AMA should raise the awareness of physicians and patients regarding the increased use of illicit benzodiazepine/opioid combinations.
11. The AMA should support initiatives to improve education and reduce barriers for the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life threatening conditions..
12. The AMA should support the disclosure to cancer and other patients of the risks to fertility when gonadotoxic treatment is used.
13. The AMA should support additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service.
14. The AMA should support counseling of women who are prescribed opioid analgesics following caesarean birth about the risk of central nervous system depression in the woman and the breastfed infant.
15. The AMA should include in educational materials for physicians regarding sex based differences in their resources related to the opioid

epidemic. These sex based differences include the perception of pain, the impact of co-morbid conditions, response to opioids etc.

16. The AMA should recognize that alcohol consumption at any level is a risk for cancer.
17. The AMA should work with medical specialty societies to preserve a physicianôs ability to prepare medications in physicianôs offices. The AMA should advocate that the preparation of medications in physiciansô office is the practice of medicine and should be defined by and remain under the purview of state medical licensing boards rather than state pharmacy boards or other state regulatory bodies.
18. The AMA should oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen. The AMA should advocate for appropriate medical evaluation prior to removal of the child.
19. The AMA supports the use of rational, scientifically based blood and tissue donation deferral periods that are fairly and consistently applied. The AMA should support a blood donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology.
20. The AMA supports keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital.
21. AMA Policy H-130.935 was amended by addition to state that the AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment and public buildings.
22. The AMA should monitor and evaluate regulation delays that impact public health and advocate as appropriate to decrease regulatory delays.
23. The AMA should collaborate with the American Heart Association to include naloxone use in training in Basic Life Support instruction.

REFERENCE COMMITTEE F ï FINANCE AND GOVERNANCE

1. There will be no changes in dues levels for 2020.
2. External consultants reviewed potential harassment issues at the HOD and recommendations were made for establishment of an anti-harassment policy for future meetings.
3. A mid year report will be issued on June 30 to inform each state medical society and each national specialty society that it is in the process of a five year review of its current AMA membership count.
4. There was a resolution asking the AMA to investigate mechanisms for AMA members to receive a discount or waiver on CPT fees. The AMA did identify an opportunity to increase the discount to 30 Percent as a member benefit for direct licenses with 25 or fewer users.
5. The AMA adopted new policy ñPrinciples for Advancing Gender Equity in Medicineò. Please see the AMA website for the full policy.
6. The compensation committee addressed policy regarding health

insurance benefits for the president. If the president becomes Medicare eligible, he or she is expected to enroll in Medicare.

7. Every AMA delegate and alternate is expected to acknowledge and accept AMA policies regarding code of conduct at AMA meetings.
8. When the AMAôs Litigation Center asked for a state medical societyôs support of an amicus brief, especially if it concerns an issue in the state, that the Litigation Center consider the stateôs point of view.
9. The AMA was asked to research possible and existing alternatives for the functions of the National Guidelines Clearinghouse and report back to the HOD.
10. The AMA should advocate for the establishment of best practices that remove any gender bias from the review and adjudication of grant applications and submissions for publications in peer reviewed journals.
11. The AMA should evaluate the TIMEôS UP healthcare program and consider participation as a partner in support of our mutual objectives to eliminate harassment and discrimination.
12. The AMA should create a speaker appointed task force to evaluate our election processes.
13. The AMAS should study the risks and benefits of collective bargaining for physicians and physicians in training in todayôs health care environment.
14. The AMA should develop a plan in conjunction with the Minority Affairs Section to improve consistency and reliability in the collection of racial and ethnic minority demographic data for physicians and medical students.
15. The AMA should study eliminating stigmatization and enhancing inclusion of physicians with disabilities.
16. The AMA should provide an online list of AMA Council and Board reports under development.

REFERENCE COMMITTEE G ï MEDICAL PRACTICE

1. BOT Report 31 recommends that the AMA advocate to oppose claim non payment, extrapolation of overpayments, and bundled payment denials based on minor wording or clinically inconsistent documentation.
2. CMS Report 8 said that the AMS should immediately ask the Secretary of HHS to request that the HHS OIG examine the supply chain of pharmaceuticals, PBMs, safe harbor laws and regulations and make recommendations to make prescription drugs more accessible and affordable.
3. CMS Report 10 encouraged the development and implementation of alternate payment models that provide services to improve the health of vulnerable and high risk populations.

4. The AMA was asked to explore emerging technologies to automate the prior authorization for medical services while advocating for reduction in the overall volume of prior authorization requirements.
5. The AMA should work with the Council for Affordable Quality Healthcare (CAQH) to reduce the frequency of required CAH reporting to twelve months or longer.
6. BOT Report 13 discussed Policy H-225.955 regarding an employed physicianôs bill of rights. See the AMA website for the full report.
7. BOT Report 15 addressed physician burnout. Please see the website for the lengthy report. The AMA will continue to address the institutional caused of physician burnout and develop mechanisms by which physicians can reduce the risks and effects of demoralization and burnout.
8. CMS Report 7 addressed hospital consolidation. See the website for the full report. The AMA will continue to work with interested state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients and physicians and hospital process.
9. CMS Report 9 states that the AMA should advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost sharing financial obligations at the time of service.
10. CMS Report 11 recommends that the AMA adopt a series of guidelines that should be considered by physicians contemplating corporate investor partnerships.
11. The AMA should encourage institutional, local and state physician wellness programs to consider developing voluntary, confidential and non discoverable peer support groups to address the ñsecond victimò phenomenon. Second victims are defined as ña health care provider involved in an unanticipated patient event, a medical error, and or a patient related injury and become victimized in the sense that they are traumatized by the eventò.
12. The AMA should work with interested state societies to support research regarding the feasibility and impact of removing patient falls with injury from Medicareôs list of ñnever eventsò. Never events are defined as events that could occur during medical care that should never happen such as wrong site surgery.
13. The AMA should ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare Rankings.
14. The AMA should encourage studies into the effect of hospital integrated system ACOs ability to generate savings and the effect of these ACOs on medical practice.
15. The AMA should work with interested national medical specialty societies to promote the importance of early detection of sepsis.

16. The AMA believes that step therapy programs create barriers to patient care and encourages health plans to instead focus utilization management protocol on review of statistical outliers.
17. The AMA should encourage hospitals to establish alternative processes to evaluate competence for the purpose of credentialing of physicians who do not meet the traditional minimum requirements needed to maintain credentials and privileges. The AMA should encourage the Joint Commission and other accrediting organizations to accept such alternative processes.
18. The AMA should express its opposition to the imminent proposed changes to the Section 10 CFR Part 35.390(b) by the Nuclear Regulatory Commission which would weaken the requirements for Authorized Users of Radiopharmaceuticals, including shortening of training and experience requirements the use of alternative pathways, and expanding the use of non physicians, with AMA advocacy for such opposition during the comment period ending July 3, 2019.

Anyone who needs more information on a particular issue mentioned above can get it on the AMA website where it is possible to review all AMA policies