# MEMORIAL RESOLUTIONS
# ADOPTED UNANIMOUSLY

## Ronald W. Klutman, MD
## Introduced by Nebraska, Iowa, Minnesota, North Dakota, South Dakota and Wisconsin

WHEREAS, Family, friends and colleagues were deeply saddened by the death of Ronald W. Klutman, on May 14, 2016, at the age of 68; and

WHEREAS, His active involvement in the profession of medicine included service on the Nebraska Academy of Family Physicians Board of Directors, serving as President of NAFP in 1994-1995 and Family Physician of the Day at the Nebraska Legislature for 29 years, a long-time member of the Nebraska Medical Association Board of Directors serving from 1991-1997, then serving as President of the NMA from 1998-1999, proceeding his BOD service by many years as Chair, NMA Commission on Legislation, and serving as Chair, North Central Medical Conference at the AMA in 2006, and

WHEREAS, He was active nationally, serving as the delegate to the AMA House of Delegates representing the NMA from 1999-2009 as our self-proclaimed “Poor Old Country Doctor,” and

WHEREAS, He served as a mentor and guide to numerous medical students throughout Nebraska and specifically those students who are active in the AMA and NMA, and

WHEREAS, His vision helped to create the local health department and Federally Qualified Health Center for his hometown, Columbus, Nebraska, continuing to serve as a director and advisor until his retirement, and

WHEREAS, Doctor Klutman’s professional life reflected a unique combination of talents as a physician, community leader, public health advocate, overall center of influence (and entertainment) and his personal life nurtured strong relationships with his family and many friends and medical school classmates from the UNMC Class of 1973, therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the contributions made by Ronald W. Klutman, MD, to the medical profession, his community and his fellow physicians by his service and advocacy for patients and physicians; and be it further

RESOLVED, That the American Medical Association House of Delegates express its sorrow and sense of loss to the family of Ronald W. Klutman, MD, and present them with a copy of this resolution.

## Charles W. Logan, MD
## Introduced by American College of Surgeons and Arkansas Medical Society

Whereas, Dr. Charles “Charlie” W. Logan, MD, FACS, a Little Rock, Arkansas urologist, passed away on June 23, 2015; and

Whereas, Dr. Logan graduated from Vanderbilt Medical School, Nashville; completed a surgical residency at Cornell Medical Center in New York City; and completed his urology residency at Baylor University College of Medicine in Houston; and

Whereas, Dr. Logan served in the U.S. Army from 1965-1967 as part of a medical unit stationed at Fort Jackson, South Carolina; and

Whereas, Following his military service, he moved to Little Rock and founded Urology Associates, where he practiced until June 2013; and

Whereas, During his extensive surgical career, he treasured his professional relationships with his physician colleagues, serving in leadership roles with the American College of Surgeons (Secretary of the Board of Governors), American Medical Association (delegate with the ACS, and Reference Committee chair), American

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Association of Clinical Urologists, American Urological Association, American Association of Pediatric Urology, Arkansas Medical Society (both as President and Chairman of the Board of Trustees), Arkansas State Urological Society, and Pulaski County Medical Society; and

Whereas, Dr. Logan was highly respected as a compassionate surgeon who demonstrated through his actions that his responsibility is to patients first and foremost; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Doctor Charles W. Logan's outstanding service to the profession of surgery and his patients; and be it further

RESOLVED, That our AMA House of Delegates extend its deepest sympathy to the family members of Charles W. Logan, MD, FACS.

**J. Allan Tucker, Jr., MD**
**Introduced by the College of American Pathologists**

Whereas J. Allan Tucker, Jr., MD, a resident of Mobile, Alabama, died peacefully on March 23, 2016, following an 18-month battle with brain cancer; and

Whereas Dr. Tucker served as the Louise Lenoir Locke Professor and Chair of Pathology as well as the director of anatomic pathology at the University of South Alabama College of Medicine prior to his passing; and

Whereas Dr. Tucker was a University of Georgia Foundation Fellow Malon C. Courts Scholar, earning his undergraduate degree in biochemistry with summa cum laude distinction; and

Whereas he earned his medical degree from Vanderbilt Medical School where he received the National Research Service Award and completed his residency in the combined anatomic and clinical pathology program at Duke University Medical Center, where he also served as chief resident. To further his training, Dr. Tucker completed a fellowship in surgical pathology and electron microscopy at Duke University Medical Center; and

Whereas the passing of Dr. Tucker is not only a loss for the Pathology Section Council, of which he was a member, but also for American medicine; and

Whereas he contributed his time to numerous professional organizations serving for a number of years both on the College of American Pathologists (CAP) Economic Affairs Committee and as the CAP's member representative to the AMA/Specialty Society Relative Value Scale Update Committee (RUC), as well as the United States and Canadian Academy of Pathology (USCAP) delegate to the AMA House of Delegates. Dr. Tucker also held leadership positions in numerous professional organizations, such as the Alabama Association of Pathologists, Alabama Imaging and Microscopy Society, the American Society for Clinical Pathology, the American Registry of Pathology Board of Directors, the Arthur Purdy Stout Society of Surgical Pathologists, the Association of Directors of Anatomic and Surgical Pathology, the Association of Pathology Chairs, the International Academy of Pathology, the Medical Association of the State of Alabama, the Medical Society of Mobile County, the Society for Ultrastructural Pathology, the Southern Medical Association Section on Pathology, and USCAP; and

Whereas Dr. Tucker's insight, intellect, and dedication to the field of pathology are rivaled only by his dedication, humor, kindness, and generosity; and

Whereas, Dr. Tucker served his patients, his community, and his profession with the utmost respect, compassion, and energy; therefore be it

RESOLVED, That the American Medical Association House of Delegates express its deep sorrow at the loss of its long-standing delegate, J. Allan Tucker, MD; and be it further

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

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# 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 12. The following resolutions were handled on the reaffirmation calendar: 105, 109, 116, 119, 220, 235, 302, 305, 306, 307, 308, 412, 508, 706 and 709.

## 1. SUPPORT FOR PERSONS WITH INTELLECTUAL DISABILITIES
**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-90.967*

RESOLVED, That our American Medical Association encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

## 2. CLARIFICATION OF MEDICAL NECESSITY FOR TREATMENT OF GENDER DYSPHORIA
**Introduced by Resident and Fellow Section**

**Resolution 2 was considered with Resolution 5. See Resolution 5.**

RESOLVED, That our American Medical Association recognize that treatment for gender dysphoria should be determined by shared decision making between patient and physician, consistent with generally-accepted standards of medical and surgical practice; and be it further

RESOLVED, That our AMA amend Policy H-185.950 by addition and deletion to read as follows:

> Removing Financial Barriers to Care for Transgender Patients H-185.950
> Our AMA supports public and private health insurance coverage for treatment of gender ~~identity disorder~~ dysphoria as recommended by the patient's physician.

## 3. SUPPORTING AUTONOMY FOR PATIENTS WITH DIFFERENCES OF SEX DEVELOPMENT
**Introduced by Medical Student Section**

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

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association affirm that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.

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## 4. TARGETED EDUCATION TO INCREASE ORGAN DONATION
**Introduced by Medical Student Section**

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

**HOUSE ACTION: ADOPTED**
*See Policy D-370.984*

RESOLVED, That our American Medical Association study potential educational efforts on the issue of organ donation tailored to demographic groups with low organ donation rates.

## 5. CLARIFICATION OF MEDICAL NECESSITY FOR TREATMENT OF GENDER DYSPHORIA
**Introduced by Young Physicians Section**

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

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**IN LIEU OF RESOLUTION 2**
*See Policies H-185.927 and H-185.950*

RESOLVED, That our American Medical Association recognize that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and be it further

RESOLVED, That our AMA advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and be it further

RESOLVED, That our AMA amend Policy H-185.950 by addition and deletion to read as follows:

> Removing Financial Barriers to Care for Transgender Patients
> Our AMA supports public and private health insurance coverage for treatment of gender ~~identity disorder~~ dysphoria as recommended by the patient's physician.

## 6. DEFINITION OF RESIDENT AND FELLOW
**Introduced by Resident and Fellow Section**

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

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Council on Constitution and Bylaws Report 3*

RESOLVED, That our American Medical Association Council on Constitution and Bylaws develop amendments to the existing bylaws to accomplish the following:

> For purposes of membership in the AMA-RFS, the term Resident shall be applied to any physician who meets at least one of the following criteria:

1. Members who are enrolled in a residency approved by the ACGME or the AOA
2. Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including undersea medical officers or flight surgeons) before their return to complete a residency program
3. Members serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency

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For purposes of membership in the AMA-RFS, the term Fellow shall be applied to any physician who has graduated from residency and meets at least one of the following criteria:

1. Members serving in fellowships approved by the ACGME or AOA
2. Members serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least six months to broaden competency in a specialized field

For purposes of membership in the AMA-RFS, any physician meeting the definition of Resident or Fellow shall be eligible for discounted membership dues to the AMA and membership within the AMA Resident and Fellow Section.

## 7. MEMBERSHIP AND REPRESENTATION IN THE ORGANIZED MEDICAL STAFF SECTION

**Introduced by Organized Medical Staff Section**

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

**HOUSE ACTION: ADOPTED**
*See Policy G-615.101*

RESOLVED, That our American Medical Association Bylaws be amended to reflect the following statements about membership and representation in the Organized Medical Staff Section (OMSS):

1. Membership. Membership in the OMSS shall be open to all active physician members of the AMA who are members of the medical staff of a hospital or members of the medical staff of a group of practicing physicians organized to provide health care. Membership in the Section also shall continue to include active resident and fellow members of the AMA who are selected by their medical staffs as representatives to the OMSS business meeting.

2. Representation.
   a. The medical staff of each hospital or group of practicing physicians organized to provide health care meeting the requirements established by the OMSS Governing Council may select up to two AMA member representatives to the OMSS business meeting; additionally, the president or chief of staff of the medical staff may attend the meeting as a representative if he or she is an AMA member.
   b. When a multi-hospital system and its component medical staffs have exercised their option under the Medicare Conditions of Participation to unify the medical staffs, the medical staff members who hold specific privileges to practice at each separately Medicare-certified hospital within the system may select up to two AMA member representatives to the OMSS business meeting. Additionally, the president or chief of staff of the unified medical staff may attend the meeting as a representative if he or she is an AMA member.
   c. All OMSS representatives shall be certified in accordance with procedures established by the OMSS Governing Council.

3. Rights of OMSS representatives. Only certified OMSS representatives shall have the right to introduce business, make motions, and vote at OMSS business meetings, and to serve as members of the OMSS Governing Council.

4. Rights of non-OMSS representatives
   a. OMSS members who are not certified OMSS representatives, as well as all other AMA members, shall have the right to attend OMSS business meetings and to speak and debate but not to introduce business, make motions, or vote.
   b. A physician who is not an AMA member may attend one business meeting as a guest, without the right to speak or debate, introduce business, make motions, or vote at OMSS business meetings.
   c. At the discretion of the Governing Council, non-physicians may attend business meetings as guests, without the right to speak or debate, introduce business, make motions, or vote.

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**8. UPDATING SEXUAL ORIENTATION AND GENDER IDENTITY POLICIES**
**Introduced by Gay and Lesbian Medical Association, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry**

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

**HOUSE ACTION: ADOPTED**
*See Policies H-65.976, H-160.991 and D-65.996*

RESOLVED, That our American Medical Association amend the title and text of HOD Policy H-160.991, Health Care Needs of the Homosexual Population, by addition and deletion to read as follows:

Health Care Needs of ~~the~~ ~~Homosexual~~ Lesbian Gay Bisexual and Transgender Populations

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities ~~and~~ ~~behavior~~ enhances the ability to render optimal patient care in health as well as in illness. In the case of ~~the homosexual~~ lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT ~~true since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population~~; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of ~~homosexuality~~ LGBT Health and the need to elicit relevant gender and sexuality information from our patients ~~to take an adequate sexual history~~; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of ~~their homosexual~~ LGBT patients; (iii) encouraging the development of educational programs in LGBT Health ~~for homosexuals to acquaint them with the diseases for which they are at risk~~; (iv) encouraging physicians to seek out local or national experts in the health care needs of ~~gay men and lesbians~~ LGBT people so that all physicians will achieve a better understanding of the medical needs of ~~this~~ these populations; and (v) working with ~~the gay and lesbian community~~ LGBT communities to offer physicians the opportunity to better understand the medical needs of ~~homosexual and bisexual~~ LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity ~~that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation~~.
2. Our AMA will ~~(a)~~ collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex ~~exclusively~~ with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and ~~(b) support our partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the~~ (iii) appropriate safe sex techniques to avoid ~~that risk~~ the risk for sexually transmitted diseases.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to ~~use the results of the survey being conducted in collaboration with the Gay and Lesbian Medical Association to serve as a needs assessment in developing such tools and online continuing medical education (CME) programs with the goal of~~ ~~increasing~~ increase physician competency on ~~gay, lesbian, bisexual, and transgender~~ LGBT health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to ~~gay men and lesbians.~~ LGBT people; and be it further

RESOLVED, That our AMA amend the title of HOD Policy D-65.996, Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population, by addition and deletion, to read as follows: Nondiscriminatory Policy for the Health Care Needs of ~~the Homosexual~~ LGBT Populations; and be it further

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RESOLVED, That our AMA amend the title of HOD Policy H-65.976, Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population, by addition and deletion, to read as follows: Nondiscriminatory Policy for the Health Care Needs of ~~the Homosexual~~ LGBT Populations.

## 9. PHYSICIAN DECISION MAKING
**Introduced by Michigan**

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

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-450.928*

RESOLVED, That our American Medical Association advocate that treating and attending physicians, regardless of employment status, must maintain overall leadership in decisions affecting the health care received by patients in order to ensure quality of the care given to patients.

## 10. RELIGIOUSLY AFFILIATED MEDICAL FACILITIES AND THE IMPACT ON A PHYSICIAN'S ABILITY TO PROVIDE PATIENT CENTERED, SAFE CARE SERVICES
**Introduced by Wisconsin**

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

**HOUSE ACTION: ADOPTED**
*See Policy D-140.956*

RESOLVED, That our American Medical Association conduct a study of access to care in secular hospitals and religiously-affiliated hospitals to include any impact on access to services of consolidation in secular hospital systems and religiously-affiliated hospital systems.

## 11. CEJA AND HOUSE OF DELEGATES COLLABORATION
**Introduced by Texas**

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

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-600.957*

RESOLVED, That our American Medical Association evaluate how the collaborative process between the House of Delegates and the Council on Ethical and Judicial Affairs can best be improved to allow HOD input to CEJA deliberation while still preserving CEJA autonomy and report back at the 2016 Interim Meeting; and be it further

RESOLVED, That our AMA evaluate how a periodic review of *Code of Medical Ethics* guidelines and reports can best be implemented and report back.

## 12. OPPOSITION TO PHYSICIAN ASSISTED SUICIDE AND EUTHANASIA
**Introduced by Louisiana**

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

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association not change its policies on opposition to physician assisted suicide or euthanasia to policies of neutrality or endorsement on the issue of physician assisted suicide or euthanasia.

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## 13. MODERNIZATION OF THE AMA CODE OF MEDICAL ETHICS
**Introduced by Louisiana**

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

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our AMA amend its Bylaws so that any proposed revisions or modernizations to our AMA *Code of Medical Ethics* will be presented to the member societies of the Federation of Medicine at least six months prior to the session of our AMA House of Delegates at which time they will be presented for affirmation on a chapter by chapter basis, with the House of Delegates having the ability to extract any item for debate and amendment before a final vote on each chapter.

## 14. MEDICAL REPORTING FOR SAFETY SENSITIVE POSITIONS
**Introduced by Aerospace Medical Association**

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

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association advocate for a uniform national policy on mandatory reporting of significant medical conditions for employees in Safety Sensitive positions to protect public safety, as well as to enhance protection of reporting physicians.

## 15. STUDY AID IN DYING AS END OF LIFE OPTION
**Introduced by Oregon**

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

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association and its Council on Judicial and Ethical Affairs, study the issue of medical aid-in-dying with consideration of (1) data collected from the states that currently authorize aid-in-dying, and (2) input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician “aid-in-dying.”

## 16. SOCIAL MEDIA TRENDS AND THE MEDICAL PROFESSION
**Introduced by Organized Medical Staff Section**

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

**HOUSE ACTION: ADOPTED**
*See Policy D-478.969*

RESOLVED, That our American Medical Association ask the Council on Ethical and Judicial Affairs to reconsider AMA Ethical Opinion E-9.124, Professionalism in the Use of Social Media.

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## 101. INCREASING AVAILABILITY AND COVERAGE FOR IMMEDIATE POSTPARTUM LONG-ACTING REVERSIBLE CONTRACEPTIVE PLACEMENT
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-75.984*

RESOLVED, That our American Medical Association recognize the practice of immediate postpartum and post-pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and be it further

RESOLVED, That our AMA support the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee; and be it further

RESOLVED, That our AMA encourage relevant specialty organizations to provide training for physicians regarding (1) patients who are eligible for immediate postpartum long-acting reversible contraception, and (2) immediate postpartum long-acting reversible contraception placement protocols and procedures.

## 102. DEVELOPING MEASURES FOR GOOD ACCESS TO CARE
**Introduced by Iowa, Minnesota, Nebraska, North Dakota, South Dakota, Wisconsin**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-450.930*

RESOLVED, That our American Medical Association collaborate with the appropriate organizations to support specialty-designed measures of access to care that ensure physicians have the measures they need to be successful under the Medicare Access and Chip Reauthorization Act (MACRA); and be it further

RESOLVED, That our AMA encourage the Centers for Medicare & Medicaid Services (CMS) to use specialty society-developed access to care measures for the Clinical Practice Improvement incentives rather than CMS-generated measures of access.

## 103. DIRECT PRIMARY CARE
**Introduced by Missouri**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-385.912*

RESOLVED, That our American Medical Association support inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service.

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### 104. SUPPORT FOR THE QUADRUPLE AIM
**Introduced by Colorado**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy H-405.955*

RESOLVED, That our American Medical Association support that the 'Triple Aim' be expanded to the Quadruple Aim, adding the goal of improving the work-life of physicians and other health care providers; and be it further

RESOLVED, That our AMA advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS).

### 105. RESTORE MEDICARE DUAL ELIGIBLE PAYMENTS
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-290.978 AND D-290.998 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association urge Congress to pass legislation to require that state Medicaid programs cover the cost-sharing amounts for patients insured by both Medicare and Medicaid.

### 106. PRE-EXPOSURE PROPHYLAXIS FOR HIV
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy H-20.895*

RESOLVED, That our American Medical Association educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines; and be it further

RESOLVED, That our AMA support the coverage of PrEP in all clinically appropriate circumstances.

### 107. ARBITRARY RELATIVE VALUE DECISIONS BY CMS
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-400.983*

RESOLVED, That our American Medical Association, together with state medical associations and national medical specialty societies, work to ensure that the resource-based relative value system and physician work values follow the statutory provisions that require the consideration of time and intensity; and be it further

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RESOLVED, That our AMA, working with state medical associations and national medical specialty societies, strongly advocate that Centers for Medicare and Medicaid Services restore the Refinement Panel to serve as the appeals process that was appropriately in place from 1993–2010.

## 108. CONTINUED SURGICAL CARE
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association seek legislation/regulation which would allow a physician who has performed an initial surgical procedure, to continue to follow the patient and perform any necessary follow-up surgery, regardless of the physician's change in participation status; and be it further

RESOLVED, That any follow-up surgery performed by a physician whose participation status changed after the initial surgery was performed, be reimbursed appropriately based on their current participation status.

## 109. DEVELOPMENT OF A CPT CODE FOR PMP LOOK-UP
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-70.919 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That since several states require physicians to check some form of Prescription Monitoring Program (PMP) registry, prior to prescribing or dispensing any Schedule II, III or IV controlled substances, a process which is not currently reimbursable but involves physicians' time and medical judgment in consideration of providing controlled prescription medications, our AMA should urge the CPT Editorial Panel to develop a Current Procedural Terminology (CPT) code so physicians in all states can be appropriately paid for their time and effort in consulting the PMP registry; and be it further

RESOLVED, That our AMA work to ensure that insurance companies reimburse for this CPT code.

## 110 OPPOSING COVERAGE DECISIONS BASED SOLELY ON ICD-10 CODE SPECIFICITY
**Introduced by American Academy of Physical Medicine and Rehabilitation**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy H-70.914*

RESOLVED, That our American Medical Association oppose limitations in coverage for medical services based solely on diagnostic code specificity.

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## 111. UPDATED STUDY ON HEALTH CARE PAYMENT MODELS
**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy D-165.936*

RESOLVED, That our American Medical Association research and analyze the benefits and difficulties of a variety of health care financing models, with consideration of the impact on economic and health outcomes and on health disparities and including information from domestic and international experiences.

## 112. HIERARCHICAL CONDITION CATEGORY CODING
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-160.928*

RESOLVED, That our American Medical Association continue to work with the Centers for Medicare & Medicaid Services to refine risk adjustment in all alternative payment models and Medicare Advantage plans, particularly to revise risk-adjustment processes, to allow hierarchical condition category (HCC) codes to automatically follow the beneficiary from year-to-year to reflect chronic conditions that will never change.

## 113. SUPPORT FOR EQUAL HEALTH CARE ACCESS FOR EATING DISORDERS
**Introduced by Wisconsin**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-185.974*

RESOLVED, That our American Medical Association modify Policy H-185.974, Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs, by addition and deletion to read as follows:

> Our AMA supports parity of coverage for mental illness, alcoholism, ~~and~~ substance use, and eating disorders.

## 114. RISK-ADJUSTMENT REFINEMENT IN ACO SETTINGS AND MEDICARE SHARED SAVINGS PROGRAMS
**Introduced by American Medical Group Association**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy D-160.927*

RESOLVED, That our American Medical Association continue seeking the even application of risk-adjustment in ACO settings to allow Hierarchical Condition Category risk scores to increase year-over-year within an agreement period for the continuously assigned Medicare Shared Savings Program beneficiaries and report progress back to this House at the 2017 Annual Meeting.

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### 115. SURVEY OF ADDICTION TREATMENT CENTERS AVAILABILITY
**Introduced by American Academy of Pain Medicine**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association survey practicing physicians about the availability of mental health resources for the treatment of addiction within their local community; and be it further

RESOLVED, That this should specifically address the availability of referrals for a) Medicare patients and b) Medicaid patients c) managed care patients and d) patients with private insurance; and be it further

RESOLVED, That our AMA publicly release the results of this study with the intention of helping to remedy the probable shortage of addiction treatment centers, especially for our Medicare and Medicaid patients.

### 116. CPT FOR REFERRAL TO AN ADDICTION TREATMENT CENTER
**Introduced by American Academy of Pain Medicine**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-70.919 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That interested stakeholders explore the creation of a new CPT code, or codes, specifically for the time and effort required for referral to an addiction treatment center.

### 117. MULTIDISCIPLINARY PAIN MANAGEMENT CENTER REIMBURSEMENT
**Introduced by American Academy of Pain Medicine**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: POLICIES H-70.919, H-185.931 AND D-160.981 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association consider alternative payment models for the reimbursement of services supplied by multidisciplinary pain management centers. The services would need to include pain physicians, physical therapists, psychologists and psychiatrists at a minimum; and be it further

RESOLVED, That our AMA consider bundled payments, global fees or other alternatives payment models for reimbursement to multidisciplinary pain management centers; and be it further

RESOLVED, That interested stakeholders consider whether additional CPT codes are required for a multidisciplinary pain management center’s reimbursement.

### 118. ADDRESSING THE HEALTH AND HEALTH CARE ACCESS ISSUES OF INCARCERATED INDIVIDUALS
**Introduced by Minority Affairs Section**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association advocate for an adequate number of health care providers to address the medical and mental health needs of incarcerated individuals; and be it further

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RESOLVED, That our AMA advocate for an adequate number of primary care and mental health personnel to provide adequate health care treatment to civilly committed (designated to correctional institutions), incarcerated, or detained individuals; and be it further

RESOLVED, That our AMA advocate for the reversal of the "inmate exclusion clause" such that detainees and inmates who are eligible for state and federally funded insurance programs in the community maintain their eligibility when they are pre-trial, detained up to one year, and within one year of release to improve health outcomes in this vulnerable populations and decrease its burden of racial and ethnic health care disparities.

## 119. ENSURING APPROPRIATE RISK ADJUSTMENT PRIOR TO IMPLEMENTATION OF VALUE BASED PURCHASING PROGRAMS

**Introduced by AMDA-The Society for Post-Acute and Long-Term Care Medicine**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-160.915 AND H-390.849 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association require the Centers for Medicare & Medicaid Services (CMS) to clearly define risk stratification indices and develop a cost to risk algorithm based on previous utilization data and incorporate unique patient characteristics including age and frailty to accurately measure Medicare Shared Savings Program/Physician performance and shared savings prior to further implementation of Value Based Purchasing (VBP) programs.

## 120. REQUIRING SECONDARY AND SUPPLEMENTAL INSURERS TO MEDICARE TO FOLLOW MEDICARE PAYMENTS

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

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-390.839*

RESOLVED, That our American Medical Association support payment by supplemental insurers of the balance of the approved Medicare payment; and be it further

RESOLVED, That our AMA support payment by secondary insurers of the balance of the approved Medicare payment in an amount bringing Medicare and secondary payments up to the full allowance of the secondary insurer for services covered by the secondary insurer.

## 121. ASSESSMENT OF THE IMPACT OF HIGH DEDUCTIBLE HEALTH PLANS ON PATIENT HEALTH AND THE FINANCIAL IMPACT ON MEDICAL PRACTICES

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

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: POLICIES H-155.960, H-165.828, H-185.939 AND D-155.987 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate for uniform (minimum) standards for improving patient education and policies regarding deductibles for preventive care and essential preventive and diagnostic services in High Deductible Health Plans; and be it further

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RESOLVED, That our AMA study the effects of High Deductible Health Plans on the access to care among patients, including lower socioeconomic income patients, and among those who were previously under- or uninsured, and to assess the upper limit of deductible cost that discourages patients from utilizing necessary care; and be it further

RESOLVED, That our AMA work with key stakeholders, such as local and national medical and specialty organizations, medical schools, and practicing physicians to develop Clinical Care Pathways to establish standards for common clinical conditions, and that our AMA further develop a classification system of High Deductible plans based on the risk incurred by the (1) patients and (2) providers; and be it further

RESOLVED, That our AMA advocate for systems that will improve health cost transparency including "real time" assessment of cost for High Deductible Health Plans, and the status of patient's deductibles at the point of service; and be it further

RESOLVED, That our AMA establish payment models for High Deductible Health Plans, which will improve both patient compliance with necessary medical care and the ability of providers to collect health care plan deductibles and other out-of-pocket expenses, such that the viability of health care systems in medically underserved communities can be assured.

## 122. HEALTH COVERAGE FOR NUTRITIONAL PRODUCTS FOR INBORN ERRORS OF METABOLISM

**Introduced by American College of Medical Genetics and Genomics**

*Reference committee hearing: see report of Reference Committee A.*

**HOUSE ACTION: ADOPTED**
*See Policy D-185.982*

RESOLVED, That our American Medical Association support legislation mandating insurance coverage with minimal deductible or copays for specialized medical food products used to treat inborn errors of metabolism; and be it further

RESOLVED, That our AMA advocate with the Department of Health and Human Services and members of Congress for the regulation of specialized nutritional products for the medical treatment of inborn errors of metabolism as drugs.

## 201. REPEAL OF ANTI-KICKBACK SAFE HARBOR FOR GROUP PURCHASING ORGANIZATIONS

**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, That our American Medical Association support the repeal of the "Anti-Kickback Safe Harbor" for Group Purchasing Organizations.

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**202. SUPPORTING LEGISLATION TO CREATE STUDENT LOAN SAVINGS ACCOUNTS**
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy H-305.926*

RESOLVED, That our American Medical Association advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

**203. OPPOSITION TO DISCLOSURE OF DRUG USE AND ADDICTION TREATMENT HISTORY IN PUBLIC ASSISTANCE PROGRAMS**
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy H-270.966*

RESOLVED, That our American Medical Association amend Policy H-270.966 by addition and deletion as follows:

> H-270.966 Disclosure of Drug Use and Addiction Treatment History in Public ~~Housing Applications~~ Assistance Programs
>
> The AMA opposes ~~Section 301-d (the Grams Amendment of the Public Housing Reform and Responsibility Act of 1997), which authorizes public housing agencies to require~~ a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance~~, and seeks its removal~~ and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program (SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status.

**204. USP COMPOUNDING RULES**
**Introduced by American Academy of Allergy, Asthma and Immunology; American Academy of Dermatology; American Academy of Facial Plastic and Reconstructive Surgery; American College of Mohs Surgery; American Academy of Ophthalmology; American Academy of Otolaryngic Allergy; American Academy of Otolaryngology-Head and Neck Surgery; American College of Allergy, Asthma and Immunology; American College of Rheumatology; American Society of Ophthalmic Plastic and Reconstructive Surgery; Arkansas; Texas; South Carolina; Tennessee; Stephen A. Imbeau, MD, Delegate**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policies H-120.930, H-120.934 and D-120.949*

RESOLVED, That our American Medical Association reaffirm Policies H-120.934 and D-120.949; and be it further

RESOLVED, That our AMA engage in efforts to convince United States Pharmacopeia (USP) to retain the current special rules for procedures in the medical office that could include but not be limited to allergen extract compounding in the medical office setting and, if necessary, engage with the U.S. Food and Drug Administration (FDA) and work with the U.S. Congress to ensure that small volume physician office-based compounding is preserved; and be it further

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RESOLVED, That our AMA undertake to form a coalition with affected physician specialty organizations such as allergy, dermatology, immunology, otolaryngology, oncology, ophthalmology, neurology and rheumatology to jointly engage with USP, FDA and the U.S. Congress on the issue of physician office-based compounding and the proposed changes to USP Chapter 797; and be it further

RESOLVED, That our AMA reaffirm that the regulation of compounding in the physician office for the physician's patients be under the purview of state medical boards and not state pharmacy boards; and be it further

RESOLVED, That our AMA support the current 2008 USP Chapter 797 sterile compounding rules as they apply to allergen extracts, including specifically requirements related to the beyond use dates of compounded allergen extract stock.

**205. AMA SUPPORT FOR JUSTICE REINVESTMENT INITIATIVES**
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-95.931*

RESOLVED, That our American Medical Association support justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

**206. MINIMIZE PROVIDER BURDEN FOR MEANINGFUL USE AUDIT**
**Introduced by Washington**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-330.906*

RESOLVED, That our American Medical Association advocate for all audit programs to have a "look back period" of no more than two years; and be it further

RESOLVED, That our AMA advocate against the "zero tolerance" policy of the current "Meaningful Use" audit program and any similar programs proposed by the Centers for Medicare and Medicaid Services, whereby physicians lose their total incentive payment rather than receive a payment proportional to their success; and be it further

RESOLVED, That our AMA advocate to reform the Centers for Medicare & Medicaid Services "Meaningful Use" audit program.

**207. NATIONAL PRACTITIONER DATA BANK**
**Introduced by Washington**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-355.974*

RESOLVED, That our American Medical Association advocate to the Health Resources and Services Administration that a physician's surrender of clinical privileges or failure to renew clinical privileges while under

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investigation should not be reported to the National Practitioner Data Bank unless the physician has been notified that an investigation is underway; and be it further

RESOLVED, That our AMA (1) recommend that medical staff bylaws require that physicians be notified in writing prior to the start of any investigation; and (2) include this recommendation in our AMA Physician's Guide to Medical Staff Organization Bylaws.

## 208. ATTORNEY ADS ON DRUG SIDE EFFECTS
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-105.985*

RESOLVED, That our American Medical Association advocate for a requirement that attorney advertising which may cause patients to discontinue medically necessary medications have appropriate and conspicuous warnings that patients should not discontinue medications without seeking the advice of their physician.

## 209. MEDICARE PART B DOUBLE DIPPING
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association seek legislation to stop the practice by the federal government of deducting Medicare Part B coverage costs from the Social Security checks of retirees, as well as from salaries individuals may earn after they draw on social security benefits.

## 210. STATUTE OF LIMITATIONS FOR MEDICARE AND RAC "LOOKBACKS"
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy D-335.982*

RESOLVED, That our American Medical Association work with Medicare to reduce the "Lookback" period to be no longer than the length of time allowed to submit a claim for consideration.

## 211. CMS REVALIDATION OF MEDICARE BILLING PRIVILEGES
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy D-390.951*

RESOLVED, That our American Medical Association advocate for the Centers for Medicare & Medicaid Services (CMS) to adopt the practice of sending revalidation notices to physicians using certified mail with return receipt, thus ensuring that such notices are actually sent by CMS and received by the physician.

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## 212. INTERSTATE MEDICAL LICENSURE COMPACT
**Introduced by Oklahoma**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association oppose the Federation of State Medical Boards' Interstate Medical Licensure Compact.

## 213. MERIT-BASED INCENTIVE PAYMENTS
**Introduced by Oklahoma**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-478.986*

RESOLVED, That our American Medical Association advocate to make the certified vendor-based EHRs accountable for the provision of reports in a format suitable to satisfy physician reporting requirements.

## 214. MEDICATIONS RETURN PROGRAM
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-135.925*

RESOLVED, That our American Medical Association update its current policy on medication disposal to support access to safe, convenient, and environmentally sound medication return for unwanted prescription medications; and be it further

RESOLVED, That our AMA support such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste; and be it further

RESOLVED, That our AMA support changes in federal law or regulation that would allow a program for medication recycling and disposal to occur.

## 215. TAX EXEMPTIONS FOR FEMININE HYGIENE PRODUCTS
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy H-270.953*

RESOLVED, That our American Medical Association support legislation to remove all sales tax on feminine hygiene products.

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## 216. HOSPITAL CONSOLIDATION
**Introduced by Washington**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association study the current market power of hospitals and hospital conglomerates in the largest state metropolitan statistical areas; and be it further

RESOLVED, That our AMA compare the market power of hospitals and hospital conglomerates and health plans; and be it further

RESOLVED, That our AMA study the effects of hospital consolidation on price, availability of services, physician satisfaction, and quality; and be it further

RESOLVED, That our AMA develop an action plan to manage adverse effects of the current consolidation of hospitals and hospital conglomerates.

## 217. PAIN AS THE FIFTH VITAL SIGN
**Introduced by Illinois**

**Resolution 217 was considered with Board of Trustees Report 19, which was adopted as amended in lieu of Resolution 217. See Board of Trustees Report 19.**

RESOLVED, That our American Medical Association advocate that pain as the fifth vital sign be eliminated from professional standards and usage.

## 218. MEASUREMENT OF DRUG COSTS TO ASSESS RESOURCE USE UNDER MACRA
**Introduced by American Society of Clinical Oncology, American College of Rheumatology, American Academy of Ophthalmology**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-385.911*

RESOLVED, That our American Medical Association work with Congress and the Centers for Medicare & Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk, unless a Physician Focused Alternative Payment Model (incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory.

## 219. DRY NEEDLING BY PHYSICAL THERAPISTS AND OTHER NON-PHYSICIAN PROVIDERS
**Introduced by Illinois**

**Resolution 219 was considered with Resolution 223. See Resolution 223.**

RESOLVED, That our American Medical Association develop policy on the issue of dry needling practice by non-physician groups including physical therapists, in order to guide this conversation at the national level; and be it further

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RESOLVED, That AMA policy on the practice of dry needling by physical therapists and other non-physician groups include, at a minimum, the benchmarking of training standards to already existing standards of training, certification, and continuing education that exist for the practice of acupuncture.

**220. MANAGING CONTROLLED SUBSTANCE HIGH UTILIZER PATIENTS**
**Introduced by Michigan**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-95.939, H-95.945 AND H-95.947 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association amend policy H-95.947 by addition to read as follows:

> Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947
> Our AMA: (1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states, pharmacies, and clinicians; (2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities; (3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, intraoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances; (4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions across state boundaries; and (5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians; and be it further

RESOLVED, That, consistent with the American Medical Association (AMA) policies H-95.945 and H-95.947, the AMA implement a coordinated effort among all state medical societies to advocate for an interstate compact whereby pharmacies and clinicians can have access to Prescription Drug Monitoring Programs controlled substances dispensing data across state boundaries.

**221. ASSURANCE AND ACCOUNTABILITY FOR EPA'S STATE LEVEL AGENCIES**
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-135.924*

RESOLVED, That our American Medical Association support requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.

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## 222. EXPEDITED REVIEW FOR CLERICAL ERRORS ON MEDICARE ENROLLMENT APPLICATIONS
**Introduced by Texas**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy D-330.905*

RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services (CMS) to create an expedited process to review minor clerical errors on enrollment applications that result in CMS deactivating the physician's billing privileges; and be it further

RESOLVED, That our AMA urge CMS to remove a physician from a potential fraud and abuse review if there is proof that the error is only related to a clerical mistake; and be it further

RESOLVED, That our AMA urge CMS to create a process that not only reactivates a physician's billing privileges but also retroactively applies the effective date to the initial date when the minor clerical error occurred and applies no penalty to payments due for care provided to Medicare beneficiaries during this time frame.

## 223. DRY NEEDLING IS AN INVASIVE PROCEDURE
**Introduced by American Academy of Physical Medicine and Rehabilitation**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTION 219**
*See Policy H-410.949*

RESOLVED, That our American Medical Association recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.

## 224. OCULAR INJURIES FROM AIR GUNS
**Introduced by American Academy of Ophthalmology**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-10.961*

RESOLVED, That our American Medical Association encourage the use and provision of protective eyewear when using air guns; and be it further

RESOLVED, That our AMA encourages education on the proper use of protective eyewear to avoid ocular injuries.

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**225. FRAUDULENT USE OF PRESCRIPTIONS**
**Introduced by American Academy of Pain Medicine**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-95.973*

RESOLVED, That our American Medical Association study current pathways that physicians have available to report possible fraudulent use of their prescriptions and disseminate this information throughout organized medicine; and be it further

RESOLVED, That our AMA promote the recommendation to provide a clear pathway for individual physicians to communicate about any possible fraudulent use of their prescriptions.

**226. OPPOSITION TO TRANS PACIFIC PARTNERSHIP**
**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, That our American Medical Association oppose US ratification of the Transpacific Partnership (TPP) as currently worded; and be it further

RESOLVED, That our AMA notify Congressional leaders, the President, and national media outlets of this policy.

**227. PHYSICIAN-PATIENT TEXT MESSAGING AND NON-HIPAA COMPLIANT ELECTRONIC MESSAGING**
**Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery Association, American College of Mohs Surgery, Society for Investigative Dermatology**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy D-478.970*

RESOLVED, That our American Medical Association study the medicolegal implications of text messaging and other non-HIPAA-compliant electronic messaging between physicians, patients and members of the health care team, with report back at the 2017 Annual Meeting; and be it further

RESOLVED, That our AMA develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients and members of the health care team.

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**228. LEGISLATIVE PAIN CARE RESTRICTIONS**
**Introduced by American Academy of Pain Medicine**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy H-95.930*

RESOLVED, That our American Medical Association oppose legislative or other policies that arbitrarily restrict a patient's ability to receive effective, patient-specific, evidence-based, comprehensive pain care.

**229. EXPANSION OF U.S. VETERANS' HEALTH CARE CHOICES**
**Introduced by Ohio**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association adopt policy that the Veterans Health Administration expand all eligible veterans' health care choices by permitting them to use funds currently spent on them through the VA system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65, to use these funds to defray the costs of Medicare premiums and supplemental coverage; and be it further

RESOLVED, That our AMA actively support federal legislation to achieve this reform of veterans' health care choices.

**230. VETERANS HEALTH ADMINISTRATION TRANSPARENCY AND ACCOUNTABILITY**
**Introduced by Ohio**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association adopt as policy that the Veterans Health Administration be required to report publicly on all aspects of its operation, including quality, safety, patient experience, timeliness, and cost effectiveness; and be it further

RESOLVED, That our AMA actively support federal legislation to achieve this reform of Veterans Health Administration transparency and accountability.

**231. CMS AUDITS AND CLAWBACKS**
**Introduced by Tennessee**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy H-290.964*

RESOLVED, That our American Medical Association undertake advocacy efforts to:

1. Persuade CMS to redefine "primary care provider" for purposes of the regulations governing the enhanced payments to primary care physicians mandated by section 1202 of the Health Care and Education

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Reconciliation Act of 2010 (“Section 1202”). Such definition should include the current providers board certified in a specialty considered primary care; or providers attesting to the 60% threshold under the same methodology as used in the parallel statutory formula in Section 5501(a) of PPACA; or, in states utilizing managed care organizations, providers who are, or have been held out by such MCOs as primary care providers by having patients assigned to such primary care providers and holding such providers out to the public as primary care providers; and the 60% Threshold formula previously utilized in attestation.

2. Persuade CMS to order that the audits conducted, or to be conducted, of the enhanced payments to primary care physicians, by state Medicaid agencies or their agents be conducted pursuant to the amended flexible formula redefining “primary care provider.”

3. Persuade CMS to order that state Medicaid agencies, or their agents, immediately cease recoupments, or hold amounts of funds already recouped in trust, until a new audit using the redefined formula can be completed.

## 232. CLOSING GAPS IN PRESCRIPTION DRUG MONITORING PROGRAMS
**Introduced by Alabama**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association advocate for the inclusion of all controlled substance prescriptions, regardless of their private, public, military or governmental source, in the reporting requirements for Prescription Drug Monitoring Programs (PDMP); and be it further

RESOLVED, That our AMA advocate for the inclusion of all controlled substances administered or dispensed by opioid treatment programs in the reporting requirements for Prescription Drug Monitoring Programs (PDMP).

## 233. INSURANCE COVERAGE PARITY FOR TELEMEDICINE SERVICE
**Introduced by Alabama**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy D-480.969*

RESOLVED, That our American Medical Association advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers; and be it further

RESOLVED, That our AMA develop model legislation to support states’ efforts to achieve parity in telemedicine coverage policies; and be it further

RESOLVED, That our AMA work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state’s medical practice statutes and its regulation falls under the jurisdiction of the state medical board.

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## 234. TELEMEDICINE ENCOUNTERS BY THIRD PARTY VENDORS
**Introduced by Virginia, Washington**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-480.968*

RESOLVED, That our American Medical Association develop model legislation and/or regulations requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent; and be it further

RESOLVED, The model legislation and/or regulations also require the vendor to abide by laws addressing the privacy and security of patients' medical information; and be it further

RESOLVED, That our AMA include in that model state legislation the following concepts based on AMA policy:

- A valid patient-physician relationship must be established before the provision of telemedicine services.
- Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
- The standards and scope of telemedicine services should be consistent with related in-person services.

RESOLVED, That our AMA educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.

## 235. UNFUNDED MANDATES ON PHYSICIANS
**Introduced by Louisiana**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-270.962 AND D-450.978 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association seek and/or support legislation or regulation that require all government mandates on physicians to comply with medical practice programs include a mechanism whereby physicians may obtain compensation for the added costs that the government mandated program places on the physician and their medical practice.

## 236. REMOVE PAIN SCORES FROM QUALITY METRICS
**Introduced by AMDA-The Society for Post-Acute and Long-Term Care Medicine**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy D-450.955*

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to remove uncontrolled pain scores from quality metrics that impact reimbursement for services rendered in the nursing facilities and from the five star rating system for nursing facilities.

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**237. COLLECTIVE BARGAINING FOR PHYSICIANS**
**Introduced by Louisiana**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association support the right of all physicians to form local and/or regional negotiating units consistent with our medical ethics and professionalism for the purpose of collectively bargaining with employers, insurers, government, or managed care entities on issues of health care quality, patient rights, and physician rights; and be it further

RESOLVED, That our AMA amend our AMA Code of Medical Ethics so that our policy will oppose any affiliation of physician negotiating units with labor unions or other entities unless such affiliation includes a right to strike.

**238. PART B DRUG PAYMENT DEMONSTRATION**
**Introduced by American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Ophthalmology, American Association of Clinical Urologists, American College of Allergy, Asthma & Immunology, American College of Gastroenterology, American Gastroenterological Association, American Society of Cataract and Refractive Surgery, American Society of Clinical Oncology**

**Resolution 238 was considered with Resolution 241. See Resolution 241.**

RESOLVED, That, in the event that the Part B drug payment demonstration proposed by the Centers for Medicare and Medicaid Services (CMS) on March 8, 2016, is not withdrawn, our American Medical Association work with CMS to ensure that significant modifications are addressed in any final rule issued for the demonstration, including but not limited to the following principles:

1. MS must evaluate changes to the Part B program in a much smaller demonstration program evaluating a) availability of high quality and affordable services; b) availability of equivalent alternative therapeutic products with price differentials; c) average total per-patient Medicare costs by drug, as well as average per-beneficiary costs; and d) phasing-in of changes to allow adjustment of operations to ensure that beneficiaries' access to care is not disrupted.

2. MS must align or consider MACRA timeframes and changes and the impact of these changes.

3. CMS must establish key exemptions to protect the most vulnerable Medicare-covered entities: a) physician groups of 25 or fewer professionals; b) physician-owned practices located in rural and medically underserved areas; c) drugs and biologics that have no alternatives with more than a 20% ASP differential; d) drugs and biologics where there are 3 or fewer members of the drug and biologic class and similar treatment efficacy; and e) a class of drugs and biologics in which at least one treatment option must be compounded or repackaged or is used off-label; and be it further

RESOLVED, That, if CMS does not respond to stakeholder input and withdraw or significantly modify the Part B drug payment demonstration according to these and other principles in any final rule that is issued, our AMA support and actively work to advance Congressional action to block the demonstration through legislation or restriction of funding.

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### 239. OPPOSITION TO THE DEPARTMENT OF VETERANS AFFAIRS PROPOSED RULEMAKING ON APRN PRACTICES
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy D-35.979*

RESOLVED, That our American Medical Association express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented; and be it further

RESOLVED, That our AMA staff assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led health care teams or to mandate that the VA adopt policy regarding the same; and be it further

RESOLVED, That our AMA call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of Advanced Practice Registered Nurses (APRNs), and comment to the Director of Regulation Management within the Department of Veterans Affairs of this position during the current comment period; and be it further

RESOLVED, That our AMA collaborate with other medical professional organizations to vigorously oppose the final adoption of the VA's proposed rulemaking expanding the role of Advanced Practice Registered Nurses (APRNs) within the VA.

### 240. PATIENT SAFETY INCIDENTS RELATED TO USE OF ELECTRONIC HEALTH RECORDS
**Introduced by Texas**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-478.985*

RESOLVED, That our American Medical Association support the Office of the National Coordinator for Health IT (ONC) efforts to implement a Health IT Safety Center to minimize EHR-related patient safety risks through collection, aggregation and analysis of data reported from EHR-related adverse patient safety events and near misses.

### 241. OPPOSITION TO THE CMS MEDICARE PART B DRUG PAYMENT MODEL
**Introduced by American Society of Clinical Oncology**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTION 238**
*See Policy D-330.904*

RESOLVED, That our American Medical Association request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model; and be it further

RESOLVED, That our AMA support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal; and be it further

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RESOLVED, That our AMA advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients; and be it further

RESOLVED, That our AMA advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.

## 242. PRESERVING A PERIOD OF STABILITY IN IMPLEMENTATION OF THE MEDICARE ACCESS AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZATION ACT (MACRA) (P.L. 114-10)

**Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery Association, American College of Mohs Surgery, Society for Investigative Dermatology**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-390.950*

RESOLVED, That our American Medical Association advocate that CMS implement MIPS and APMs as is consistent with congressional intent when MACRA was enacted; and be it further

RESOLVED, That our AMA advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs; and be it further

RESOLVED, That our AMA advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

## 243. PRESERVING PATIENT ACCESS TO SMALL PRACTICES UNDER MACRA

**Introduced by California**

*Reference committee hearing: see report of Reference Committee B.*

**HOUSE ACTION: ADOPTED**
*See Policy D-390.949*

RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs; and be it further

RESOLVED, That our AMA advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas; and be it further

RESOLVED, That our AMA determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

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**301. RECOGNIZING THE ACTUAL COSTS OF STUDENT LOANS**
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-305.984*

RESOLVED, That our American Medical Association consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates; and be it further

RESOLVED, That our AMA amend Policy D-305.984 by addition to include Grad-PLUS loans, as follows:

Reduction in Student Loan Interest Rates D-305.984
1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program <u>and the Graduate PLUS loan program</u>.

RESOLVED, That our AMA advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden; and be it further

RESOLVED, That our AMA work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

**302. REFORM AND EXPAND GRADUATE MEDICAL EDUCATION FUNDING**
**Introduced by Minnesota, Iowa, Nebraska, South Dakota, Wisconsin**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-305.929 AND D-305.967 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association advocate to reform the current graduate medical education financing system to include an increased allocation of targeted funding directly to primary care residency positions; and be it further

RESOLVED, That our AMA develop recommendations that would assist state medical associations in seeking new state options for alternative funding sources directed to ambulatory-based residency training focused on increasing the primary care physician workforce.

**303. RESEARCH AND MONITORING TO ENSURE ETHICS OF GLOBAL HEALTH PROGRAMS**
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: ADOPTED**
*See Policy H-250.993*

RESOLVED, That our American Medical Association amend Policy H-250.993 by addition to read as follows:

H-250.993 Overseas Medical Education Developed by US Medical Associations

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The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measureable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and (6) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLO™), to increase student participation in international electives.

## 304. EVALUATION OF FACTORS DURING RESIDENCY AND FELLOWSHIP THAT IMPACT ROUTINE HEALTH MAINTENANCE

**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association study ways to improve access and reduce barriers to seeking preventive and routine physical and mental health care for trainees in graduate medical education programs.

## 305. EXPANDING GME CONCURRENTLY WITH UME

**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-305.929 AND D-305.967 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association support the expansion of residency slots with a view to the current and future needs of the United States population.

## 306. MAINTENANCE OF CERTIFICATION / LICENSURE (MOC/MOL)

**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-275.924 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association reaffirm the AMA's policy regarding Maintenance of Certification and Maintenance of Licensure programs.

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**307. DIVERSITY IN THE HEALTH CARE WORKFORCE TO REDUCE DISPARITIES**
**Introduced by International Medical Graduates Section**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-200.951, H-295.878, D-200.982, D-200.985 AND D-350.995 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work to support the creation of initiatives for a diverse physician workforce which includes, race, ethnicity, gender, sexual orientation, socioeconomic origins, medical schools attended (either abroad or outside USA) and persons with disabilities.

**308. STATE PROGRAMS TO INCREASE RESIDENCY POSITIONS**
**Introduced by International Medical Graduates Section**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES D-305.967 AND D- D-310.977 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with states to find innovative ways to increase the number of residency positions to accommodate unmatched medical graduates; and be it further

RESOLVED, That our AMA present an annual report to the House of Delegates on the impact of having state-based initiatives.

**309. CONTINUING MEDICAL EDUCATION PATHWAY FOR RECERTIFICATION**
**Introduced by Florida, California, Georgia, Pennsylvania, Washington, New York, Virginia**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policies H-275.924 and D-275.954*

RESOLVED, That our American Medical Association call for the immediate end of any mandatory, secured recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process for all those specialties that still require a secure recertification examination; and be it further

RESOLVED, That our AMA continue to support requirement of Continuing Medical Education (CME) and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients; and be it further

RESOLVED, That our AMA continue to work with the American Board of Medical Specialties (ABMS) to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high-stakes exam; and be it further

RESOLVED, That our AMA support a recertification process based on high quality, appropriate CME material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning; and be it further

RESOLVED, That our AMA reaffirm Policies H-275.924 and D-275.954.

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**310. STANDARDIZING THE ALLOPATHIC RESIDENCY MATCH SYSTEM AND TIMELINE**
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association support the movement toward a single United States residency match system and notification timeline for all non-military allopathic specialties; and be it further

RESOLVED, That our AMA work with the Association of University Professors in Ophthalmology, American Academy of Ophthalmology, the Society of University Urologists, the American Urological Association, and any other appropriate stakeholders to switch ophthalmology and urology to the National Resident Matching Program.

**311. TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS**
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: ALTERNATIVE RESOLUTION 311 ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 311, 316, 317 AND 321**
*See Policy D-295.988*

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination; and be it further

RESOLVED, That our AMA work to: 1) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; 2) encourage a significant and expeditious increase in the number of available testing sites; 3) allow international students and graduates, to take the same examination at any available testing site; 4) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and, 5) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.

**312. SPECIALTY BOARD REPORT CARDS**
**Introduced by Pennsylvania**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association evaluate and prepare for distribution to the House of Delegates by the June 2017 Annual Meeting (A-17) an analysis report card comparing ABIM and NBPAS to the standards codified within AMA Policy H-275.924 (AMA Principles on Maintenance of Certification); and be it further

RESOLVED, That each succeeding year the AMA evaluate and annually prepare for distribution to the House of Delegates an Analysis Report Card comparing two separate and additional specialty boards, to be selected on a

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rotating and inclusive basis, from those Specialty Boards operating under the auspices of the American Board of Medical Specialties (ABMS) to the standards codified within AMA Policy H-275.924 (AMA Principles on Maintenance of Certification).

## 313. ACCME PROPOSED CHANGES IN "ACCREDITATION WITH COMMENDATION" CONTINUING MEDICAL EDUCATION (CME) CRITERIA ASSESSMENT METHODOLOGY

**Introduced by West Virginia**

*Reference committee hearing: see report of* [*Reference Committee C*](). 

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-300.977*

RESOLVED, That our American Medical Association continue to monitor the proposed Accreditation Council of Continuing Medical Education (ACCME) "Accreditation with commendation" criteria, provide input to the ACCME Board of Directors, and report to the AMA HOD once the criteria are approved and implemented.

## 314. ADDICTION MEDICINE AS A MULTI-SPECIALTY SUBSPECIALTY

**Introduced by American Society of Addiction Medicine**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-300.962*

RESOLVED, That our American Medical Association commend the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards; and be it further

RESOLVED, That our AMA encourage the ABPM to offer the first ABMS-approved certification examination in addiction medicine expeditiously in order to improve access to care to treat addiction.

## 315. MAINTENANCE OF CERTIFICATION (MOC) AND LICENSURE (MOL) VS BOARD CERTIFICATION, CME AND LIFE-LONG COMMITMENT TO LEARNING

**Introduced by Tennessee**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: REFERRED**

RESOLVED, That the American Medical Association oppose discrimination by any hospital or employer, state board of medical licensure, insurers, Medicare, Medicaid, and other entities, which results in the restriction of a physician's right to practice medicine without interference (including discrimination by varying fee schedules) due to lack of recertification or participation in a Maintenance of Licensure, Maintenance of Certification program, or due to a lapse of a time-limited board certification.

Note: the following proposed amendment was also referred:
RESOLVED, That our AMA shall develop an action plan to protect physicians when the Maintenance of Certification is punitively used as a requirement for licensure, credentialing, reimbursement, network participation or employment with a report back at Interim 2016.

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## 316. TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

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

**Resolution 316 was considered with Resolutions 311, 317 and 321. See Resolution 311.**

RESOLVED, That our American Medical Association, working with the state medical societies, advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school-administered, clinical skills examination; and be it further

RESOLVED, That our AMA advocate for medical schools and medical licensure stakeholders to create standardizing a clinical skills examination that would be administered at each Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school in lieu of United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) and that would be a substitute prerequisite for future licensure exams; and be it further

RESOLVED, That our AMA amend Policy D-295.998 by addition to read as follows:

> Required Clinical Skills Assessment During Medical School
> Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited institutions pass a school-administered, clinical skills examination to graduate from medical school.

## 317. TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO U.S. MEDICAL SCHOOLS

**Introduced by Arizona**

**Resolution 317 was considered with Resolutions 311, 316 and 321. See Resolution 311.**

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards and state medical licensing boards to advocate for the elimination of the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) exam as a requirement for Liaison Committee on Medical Education-accredited graduates who have passed a school-administered, clinical skills examination; and be it further

RESOLVED, That our AMA amend Policy D-295.998 by addition and deletion to read as follows:

> Required Clinical Skills Assessment During Medical School D-295.998
> Our AMA will advocate that ~~encourage its representatives to~~ the Liaison Committee on Medical Education (LCME) ~~to ask the LCME, to~~ 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited institutions pass a school-administered clinical skills examination to graduate from medical school.

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**318. EXPANSION OF PUBLIC SERVICE LOAN FORGIVENESS**
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: ADOPTED**
*See Policy D-305.993*

RESOLVED, That our American Medical Association study mechanisms to allow residents and fellows working in for-profit institutions to be eligible for Public Service Loan Forgiveness.

**319. SPECIALTY-SPECIFIC ALLOCATION OF GME FUNDING**
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: ADOPTED**
*See Policy H-305.929*

RESOLVED, that our AMA support specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

**320. EXPANDING GME CONCURRENTLY WITH UME**
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: ADOPTED**
*See Policy D-305.967*

RESOLVED, That our American Medical Association study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.

**321. TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS**
**Introduced by Medical Student Section**

**Resolution 321 was considered with Resolutions 311, 316 and 317. See Resolution 311.**

RESOLVED, That our American Medical Association, working with the state medical societies, advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school administered, clinical skills examination; and be it further

RESOLVED, That our AMA amend D-295.998 by insertion and deletion as follows:

> Required Clinical Skills Assessment During Medical School D-295.998
>
> Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills~~.~~, and 2) require that medical students attending

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LCME-accredited institutions pass a school-administered clinical skills examination to graduate from medical school; and be it further

RESOLVED, That our AMA advocate for medical schools and medical licensure stakeholders to create guidelines standardizing the clinical skills examination that would be administered at each LCME-accredited and COCA-accredited medical school in lieu of USMLE Step 2 CS and COMLEX Level 2-PE and would be a substitute prerequisite for future licensure exams.

**401. EVIDENCE-BASED SEXUAL EDUCATION IN SCHOOL**
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy H-170.968*

RESOLVED, That our American Medical Association encourage physicians and all interested parties to develop best-practice, evidence-based guidelines sexual education curricula that are developmentally appropriate as well as medically, factually and technically accurate.

**402. ADDRESSING SEXUAL ASSAULT ON COLLEGE CAMPUSES**
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED**
*See Policy H-515.956*

RESOLVED, That our American Medical Association support universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting.

**403. POLICIES ON INTIMACY AND SEXUAL BEHAVIOR IN RESIDENTIAL AGED-CARE FACILITIES**
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED**
*See Policy H-280.946*

RESOLVED, That our American Medical Association urge long-term care facilities and other appropriate organizations to adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations; and be it further

RESOLVED, That our AMA urge long-term care facilities and other appropriate organizations to provide staff with in-service training to develop a framework to address intimacy in their patient population.

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**404. VACCINE AVAILABILITY IN SMALL QUANTITIES**
**Introduced by Georgia**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED**
**TITLE CHANGED**
*See Policy H-440.877*

RESOLVED, That our American Medical Association encourage vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.

**405. SEXUAL VIOLENCE EDUCATION AND PREVENTION IN SCHOOLS**
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy H-170.968*

RESOLVED, That our AMA amend Policy H-170.968 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; ~~(b)~~(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; ~~(c)~~(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; ~~(d)~~(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;~~(e)~~(f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and ~~(f)~~(g) 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, 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; and (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, conversations about consent.

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## 406. RESEARCH THE EFFECTS OF PHYSICAL OR VERBAL VIOLENCE BETWEEN LAW ENFORCEMENT OFFICERS AND PUBLIC CITIZENS ON PUBLIC HEALTH OUTCOMES

**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-515.955*

RESOLVED, That our American Medical Association encourage the National Academies of Sciences, Engineering and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities; and be it further

RESOLVED, That our AMA affirm that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health; and be it further

RESOLVED, That our AMA encourage the Centers for Disease Control and Prevention as well as state and local health departments and agencies to research the nature and public health implications of violence involving law enforcement.

## 407. TOBACCO PRODUCTS IN PHARMACIES AND HEALTHCARE FACILITIES

**Introduced by New York**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: POLICY H-495.977 AMENDED IN LIEU OF RESOLUTION 407**

Policy H-495.977 amended by addition and deletion to read as follows:

Banning the Sale of Tobacco Products in Pharmacies and Health Care Facilities ~~and/or Tobacco By-Products in Retail Outlets Housing Store-Based Health Clinics~~
Our AMA supports efforts to ban the sale of tobacco products ~~and/or tobacco by-products~~ meeting the definition of "tobacco product" under the Family Smoking Prevention and Tobacco Control Act, with the exception of medicinal nicotine products approved by the FDA, where health care is delivered or where prescriptions are filled, including retail outlets housing store-based health clinics.

**Resolution 408 moved to Reference Committee E. See Resolution 519.**

## 409. SAFE DRINKING WATER

**Introduced by Oklahoma**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ALTERNATIVE RESOLUTION 409 ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 409, 413, 414, 415 AND 416**
*See Policy H-135.928*

SAFE DRINKING WATER
RESOLVED, That 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;

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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. 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. Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations;
7. 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. Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act.

### 410. PRIMARY CARE INTERVENTIONS TO SUPPORT BREASTFEEDING
**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy H-245.982*

RESOLVED, That our American Medical Association adopt policy supporting the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

### 411. PROTECTING CHILDREN FROM EXCESS SOUND EXPOSURE AND HEARING LOSS
**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-440.897*

RESOLVED, That our American Medical Association adopt pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL, or greater than 90 dB SPL for more than one hour; and be it further

RESOLVED, That our AMA work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL, or greater than 90 dB SPL; and be it further

RESOLVED, That our AMA work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss.

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**412. BAN ELECTRONIC CIGARETTE ADVERTISEMENTS**
**Introduced by Michigan**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-495.973 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association, consistent with AMA Policy H-495.973, advocate by any means necessary for a total ban of electronic cigarette advertising on television and radio.

**413. BAN LEAD IN PLUMBING**
**Introduced by Michigan**

**Resolution 413 was considered with Resolutions 409, 414, 415 and 416. See Resolution 409.**

RESOLVED, That our American Medical Association pursue lead-free standards at the federal level that are actually lead-free, for all plumbing related to drinking water.

**414. REPLACE MUNICIPAL LEAD PLUMBING**
**Introduced by Michigan**

**Resolution 414 was considered with Resolutions 409, 413, 415 and 416. See Resolution 409.**

RESOLVED, That our American Medical Association strongly advocate that the United States of America end the man-made scourge of lead in drinking water by taking swift action to support the replacement of lead plumbing throughout our country.

**415. REGULAR MONITORING OF WATER AT SCHOOL AND DAYCARE SITES**
**Introduced by Michigan**

**Resolution 415 was considered with Resolutions 409, 413, 414 and 416. See Resolution 409.**

RESOLVED, That our American Medical Association lobby at the federal level for the following mandates: 1) that all schools and registered daycare sites be among those sites routinely chosen by municipal water quality assurance testing as part of the Safe Drinking Water Act enforcement; and 2) in cases where there are abnormal test results from water testing at schools and registered daycare sites, that those sites continue to be tested repeatedly until results return to normal.

**416. TIMELY AND TRANSPARENT DATA SHARING FOR DRINKING WATER TESTING**
**Introduced by Michigan**

**Resolution 416 considered with Resolutions 409, 413, 414 and 415. See Resolution 409.**

RESOLVED, That our American Medical Association lobby at the federal level for legislation, regulations, and/or policies that would do the following:

1. Require all municipal water test results performed by municipal, city, county, district or state agencies to be posted on a publicly available website within seven business days of their receipt.
2. Require all communicable disease reports performed by city, county, district or state agencies to be posted on a publicly available website within seven business days of their receipt.
3. Require reports of sewage overflows to be posted on a publicly available website within four hours of the receipt of such reports.
4. Create and make available a real-time alert system for all water test results, which exceed federal, state, or local standards within a person’s designated zip code(s), to which the public could subscribe.

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5. Create and make available a process in which all collected test results related to the quality of water that are excluded from final data analysis are annotated and explained.

### 417. CHANGING PUBLIC POLICY TO ASSIST OBESITY GOALS
**Introduced by California**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association support efforts to limit the consumption of foods and beverages that contain added sweeteners, including but not limited to, ending corn subsidies for the production of high fructose corn syrup.

### 418. CHALLENGING THE PRO-TOBACCO ACTIONS OF THE U.S. CHAMBER OF COMMERCE
**Introduced by California**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-505.961*

RESOLVED, That our American Medical Association strongly object to any pro-tobacco efforts by the U.S. Chamber of Commerce and encourage the U.S. Chamber of Commerce to be transparent in all advocacy activity on behalf of tobacco companies; and be it further

RESOLVED, That our AMA urge conscientious companies that are members of the U.S. Chamber of Commerce to call for an end to all pro-tobacco efforts within the organization.

### 419. OPPOSITION TO QUARANTINE FOR ZIKA PATIENTS
**Introduced by American College of Preventive Medicine**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED**
*See Policy H-440.826*

RESOLVED, That our American Medical Association oppose quarantine measures for Zika-infected patients.

### 420. FUND FOR PUBLIC HEALTH EMERGENCY RESPONSE
**Introduced by American College of Preventive Medicine**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy H-440.825*

RESOLVED, That our American Medical Association support the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.

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**421. RATIONAL REGULATION OF ELECTRONIC NICOTINE DELIVERY SYSTEMS (ENDS)**
**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association oppose measures that would have the practical effect of imposing more burdensome regulatory burdens on electronic nicotine delivery systems (ENDS) than on more hazardous combustible cigarettes; and be it further

RESOLVED, That our AMA oppose measures that would have the practical effect of making cigarette companies the dominant manufacturers and marketers of electronic nicotine delivery systems (ENDS) products; and be it further

RESOLVED, That our AMA oppose measures that would have the practical effect of eliminating electronic nicotine delivery systems (ENDS) from the U.S. market as long as combustible cigarettes are marketed to, and smoked by, a significant proportion of Americans.

**422. SUNSCREEN USE AT SCHOOLS AND SUMMER CAMPS**
**Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery Association, American College of Mohs Surgery, Society for Investigative Dermatology**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED**
*See Policy H-440.841*

RESOLVED, That our American Medical Association develop an educational campaign focused on the importance of reducing mid-day sun exposure and of using sunscreen and sun protective clothing for children at school and summer camp programs, with report back at the 2016 Interim Meeting; and be it further

RESOLVED, That our AMA work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs.

**423. CORE MEASURE FOR FLU VACCINATION**
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association study the benefits and risks of systematically administering flu vaccinations to post-operative patients in the hospital setting, with report back at the 2016 Interim Meeting.

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**424. ENHANCED ZIKA VIRUS PUBLIC HEALTH ACTION – NOW**
**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**IN LIEU OF RESOLUTION 431**
*See Policy D-440.930*

RESOLVED, That our American Medical Association urge Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus, commensurate with the public health emergency that the virus poses, without diverting resources from other essential health initiatives; and be it further

RESOLVED, That our AMA work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed United States and global strategies and limit the spread and impact of this virus; and be it further

RESOLVED, That our AMA consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women.

**425. OPPOSE EFFORTS TO STOP, WEAKEN OR DELAY FDA's AUTHORITY TO REGULATE ALL TOBACCO PRODUCTS**
**Introduced by American Thoracic Society**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-495.993*

RESOLVED, That our American Medical Association encourage Congress to oppose any legislation that would stop, weaken or delay FDA's authority to fully regulate all tobacco products; and be it further

RESOLVED, That our AMA write a letter to the Administration expressing our strong opposition to the decision to strike from the Food and Drug Administration's deeming rule on tobacco products, the restriction of flavored electronic nicotine delivery systems.

**426. WEAPONS, HOSPITAL WORKPLACE AND PATIENT SAFETY ISSUES**
**Introduced by Minority Affairs Section**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policies H-145.975, H-215.977 and H-345.974*

RESOLVED, That our American Medical Association advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present; and be it further

RESOLVED, That our AMA reaffirm Policies H-145.975, H215.977 and H-345.974.

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**427. COMMUNITY BENEFIT DOLLARS FOR DIABETES PREVENTION**
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-215.961*

RESOLVED, That our American Medical Association support allocating community benefit dollars to cover the cost of enrolling patients in an in-person or virtual diabetes prevention program that is part of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program; and be it further

RESOLVED, That our AMA work with the American Hospital Association and other stakeholders to develop and disseminate a position paper with guidance for covering the costs of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program with community benefit dollars; and be it further

RESOLVED, That our AMA encourage each state medical society to work with their respective hospitals and local Diabetes Prevention Program providers to offer the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients; and be it further

RESOLVED, That our AMA encourage that private and public payors offer the Centers for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients as part of their suite of benefits.

**428. LEAD CONTAMINATION IN MUNICIPAL WATER SYSTEMS AS EXEMPLIFIED BY FLINT, MICHIGAN**
**Introduced by National Medical Association**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
**TITLE CHANGED**
*See Policy H-60.918*

RESOLVED, That our American Medical Association advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure; and be it further

RESOLVED, That our AMA urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL; and be it further

RESOLVED, That our AMA advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium sources so that their bodies will not be forced to substitute lead for missing calcium as the children grow; and be it further

RESOLVED, That our AMA promote screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water.

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### 429. APPROPRIATE LABELING OF SLEEP PRODUCTS FOR INFANTS
**Introduced by Massachusetts**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ALTERNATIVE RESOLUTION 429 ADOPTED IN LIEU OF RESOLUTION 429**
*See Policy H-245.977*

RESOLVED, That our American Medical Association advocate for the appropriate labeling of all infant sleep products, not in compliance with the Safe Infant Sleeping Environment Guidelines, as adopted by the American Academy of Pediatrics, to adequately warn consumers of the risks of product use and prevent sudden unexpected infant death; and be it further

RESOLVED, That our AMA encourage consumers to avoid commercial devices marketed to reduce the risk of SIDS, including: wedges, positioners, special mattresses, and special sleep surfaces; and be it further

RESOLVED, That our AMA encourage media and manufacturers to follow safe-sleep guidelines in their messaging and advertising.

### 430. SUPPORT FOR DETERGENT POISONING AND CHILD SAFETY ACT
**Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont**

*Reference committee hearing: see report of Reference Committee D.*

**HOUSE ACTION: ADOPTED**
*See Policy D-60.967*

RESOLVED, That our American Medical Association advocate to the state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements and that these products are manufactured to be less attractive to children in color and in design and to include conspicuous warning labels; and be it further

RESOLVED, That our AMA advocate that the detergent product package labeling be constructed in a clear and obvious method so children know that the product is dangerous to ingest.

### 431. FUNDING FOR ZIKA CONTROL AND RESEARCH
**Introduced by American Academy of Family Physicians, American Academy of Neurology, American Academy of Ophthalmology, American Academy of Pediatrics, American Association of Public Health Physicians, American College of Physicians, American Congress of Obstetricians and Gynecologists**

**Resolution 431 was considered with Resolution 424. See Resolution 424.**

RESOLVED, That our American Medical Association urge Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus commensurate with the public health emergency that the virus poses without diverting resources from other essential health initiatives.

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**501. DISCLOSURE OF SCREENING TEST RISK AND BENEFITS PERFORMED WITHOUT A DOCTOR'S ORDER**
**Introduced by Virginia**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association advocate that in the absence of an established physician-patient relationship and order for screening tests not rated "A" or "B," the vendor of the wellness program should inform the patient of the USPSTF recommendation including that the evidence does not support the screening test; and be it further

RESOLVED, That our AMA advocate that if the test is not listed as an "A" or "B" by the USPSTF and the patient still would like the screening test, the wellness program vendor should offer the patient the opportunity to discuss the risks, benefits, and alternatives with a physician; and be it further

RESOLVED, That our AMA engage with federal regulators on whether for-profit vendors of health and wellness programs are in compliance with regulations applicable to marketing to consumers in view of the impact of such programs on patients; and be it further

RESOLVED, That, where possible, our AMA continue to work with state medical societies and state agencies to provide education.

**502. IN-FLIGHT MEDICAL EMERGENCIES**
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: POLICIES H-45.978, H-45.979 AND H-45.981 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with the Federal Aviation Administration (FAA) and other appropriate organizations to require airlines to provide a list of available in-flight medical supplies in accessible locations; and be it further

RESOLVED, That our AMA work with the FAA and other appropriate organizations to facilitate the creation of a centralized and standardized system to report all medical emergencies requiring assistance from a medically-trained passenger or from ground-based communications; and be it further

RESOLVED, That our AMA work with the FAA and other appropriate organizations to ensure that a routine process exists to verify functionality of medical equipment and medicines used for in-flight medical emergencies.

**503. COST-EFFECTIVE TECHNOLOGIES AS A SOLUTION TO WANDERING PATIENTS WITH ALZHEIMER'S DISEASE AND OTHER RELATED DEMENTIAS**
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED**
*See Policy H-25.991*

RESOLVED, That our American Medical Association support the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and

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rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations.

### 504. CONSERVATION, RECYCLING AND ENVIRONMENTAL STEWARDSHIP
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: POLICY H-135.939 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association encourage all health systems to facilitate effective and robust recycling programs with a recommended goal of a 25% rate when feasible; and be it further

RESOLVED, That our AMA encourage all undergraduate and graduate medical education programs to facilitate effective and robust recycling programs when feasible; and be it further

RESOLVED, That our AMA encourage health systems, medical schools, and graduate medical education offices to evaluate their overall environmental impact, create goals for improvement and create a plan and a timeline to meet those goals; and be it further

RESOLVED, That our AMA support resources and incentives that aid and encourage hospital employees and physicians who partake in environmentally conscientious activities (benefits for carpooling or taking the bus, showers at work for biking/jogging to work, etc.).

### 505. RADON TESTING IN RENTALS
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: POLICY H-455.986 AMENDED IN LIEU OF RESOLUTION 505**

Policy H-455.986 amended by addition and deletion to read as follows:

> Radon in ~~Homes~~ Residential Dwellings and other Buildings
> The AMA supports (1) assuming a leadership role in educating physicians, others of the health care community, and the public concerning the significance of radon levels in ~~homes~~ residential dwellings and other buildings and the possible health effects of those levels; and (2) encouraging the real estate community to increase transparency and disclosure of prior radon testing, and the most recent results of such testing.

### 506. HEART DISEASE AND WOMEN
**Introduced by Women Physicians Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-525.975*

RESOLVED, That our American Medical Association supports increased awareness and education on preventive measures for heart disease in women and encourages comprehensive care of heart disease in women; and be it further

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RESOLVED, That our AMA urges research to address the gaps in knowledge related to coronary pathophysiology and diagnostic, treatment, and interventional strategies for heart disease in women; and to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women.

## 507. INTERVENTIONS FOR OPIOID DEPENDENT PREGNANT WOMEN
**Introduced by Women Physicians Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ALTERNATE RESOLUTION 507 ADOPTED IN LIEU OF RESOLUTION 507**
*See Policies H-420.962 and H-420.969*

RESOLVED, that Policy H-420.969 Legal Interventions During Pregnancy be reaffirmed; and be it further

RESOLVED, that Policy H-420.962 Perinatal Addiction-Issues in Care and Prevention be amended by addition and deletion to read as follows:

The AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant <u>patients with</u> substance ~~abusers~~ <u>use disorders</u> should be provided with <u>physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation</u> ~~rehabilitative treatment appropriate to their specific physiological and psychological needs;~~ and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol ~~abuse~~ <u>use</u> during pregnancy and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

## 508. BANNING THE USE OF GASOLINE POWERED LEAF BLOWERS
**Introduced by New York**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-135.998, H-440.864 AND D-135.986 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association call upon the Environmental Protection Agency and the manufacturers of gas leaf blowers to develop guidelines that would dramatically reduce the toxic emissions and noise level of gas leaf blowers; and be it further

RESOLVED, That our American Medical Association encourage all State and Federal governmental entities to promote the use of non-polluting alternatives to gas leaf blowers.

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## 509. KRATOM AND ITS GROWING USE WITHIN THE UNITED STATES
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED**
*See Policy H-95.934*

RESOLVED, That our American Medical Association support legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.

## 510. REUNITING MILITARY SERVICE DOGS WITH SERVICE PERSONNEL HANDLERS AFTER RETIREMENT TO REDUCE PTSD
**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association work with appropriate federal and state organizations to support ways in which service animals can be reunited with their military handlers as a way to reduce the symptoms of and treat Post Traumatic Stress Disorder in our retired service men and women.

## 511. TRANSPARENCY IN TELEVISION ADVERTISING OF UNREGULATED MEDICATIONS AND MEDICAL DEVICES
**Introduced by Illinois**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: POLICY H-150.954 AMENDED IN LIEU OF RESOLUTION 511**

Policy H-150.954 amended by addition and deletion to read as follows:

Dietary Supplements and Herbal Remedies
(1) Our AMA will work with the FDA to educate physicians and the public about FDA's MedWatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies. (2) Our AMA continues to urge Congress to modify the Dietary Supplement Health and Education Act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling; (c) meet FDA postmarketing requirements to report adverse events, including drug interactions; and (d) pursue the development and enactment of legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement. (3) Our AMA work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements. (4) Our AMA supports t~~T~~hat the product labeling of dietary supplements and herbal remedies: (a) that bear structure/function claims contain the following disclaimer as a minimum requirement: "This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease." This product may have significant adverse side effects and/or interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product; (b) should not contain prohibited disease claims. (5) Our AMA supports the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies. (6) ~~(5)~~ Our AMA urges t~~T~~hat in order to protect the public, manufacturers be required to investigate

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and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label. ~~(6)~~ (7) Our AMA continue its efforts to educate patients and physicians about the possible ramifications associated with the use of dietary supplements and herbal remedies.

**512. OPPOSITION TO USP 800**
**Introduced by American Society of Clinical Oncology, American College of Rheumatology**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED**
*See Policy D-120.941*

RESOLVED, That our American Medical Association work with stakeholders to advocate against policies mandating adherence to those elements of United States Pharmacopeial Convention's (USP) General Chapter 800, "Hazardous Drugs – Handling in Healthcare Settings," that have unproven and uncertain value.

**513. ACTION TO ADDRESS ILLEGAL METHAMPHETAMINE PRODUCTION**
**Introduced by Michigan**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy 95.933*

RESOLVED, That our American Medical Association supports: (1) the widespread and proper use of the National Precursor Log Exchange (NPLEx) for pseudoephedrine-containing OTC products; (2) the replacement of current pseudoephedrine-containing OTC products with formulations that are resistant to methamphetamine production; and (3) initiatives that focus on prevention and treatment of methamphetamine abuse.

**514. OPPOSING TAX DEDUCTIONS FOR DIRECT-TO-CONSUMER ADVERTISING**
**Introduced by California**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association oppose allowing costs for direct-to-consumer advertising of prescription medications, medical devices, and controlled drugs to be considered deductible business expenses for tax purposes.

**515. NPS REPORT DISTRIBUTION TO PRACTICING PHYSICIANS**
**Introduced by American Academy of Pain Medicine**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED**
*See Policy D-120.940*

RESOLVED, That our American Medical Association distribute and promote the National Pain Strategy report to practicing physicians.

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**516. EDUCATING CLINICIANS AND THE PUBLIC ABOUT AMEBIC MENINGOENCEPHALITIS**
**Introduced by American Association of Public Health Physicians**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-440.824*

RESOLVED, That our American Medical Association support CDC training and education efforts relating to Primary Amebic Meningoencephalitis (PAM); and be it further

RESOLVED, That our AMA support clinical guidelines and standards of care that promote rapid diagnosis and effective treatment of PAM.

**517. CARDIOPULMONARY RESUSCITATION (CPR) IN POST-ACUTE AND LONG-TERM CARE**
**Introduced by AMDA-The Society for Post-Acute and Long-Term Care Medicine**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: POLICY H-140.845 REAFFIRMED**
**IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association further promulgate information to health care professionals and consumers to promote informed decision-making about Cardiopulmonary Resuscitation (CPR) by patients and their families.

**518. PROMOTION OF MILLILITER-ONLY FOR LIQUID MEDICATION DOSING**
**Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-120.939*

RESOLVED, That our American Medical Association advocate to relevant federal and state entities for the exclusive use of metric-based dosing with milliliters (mL) and milligrams (mg) for orally administered liquid medications; and be it further

RESOLVED, That our AMA advocate that dispensing pharmacies be required to provide a device calibrated in milliliters for medication administration.

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**519. SUPPORT FOR HEMORRHAGE CONTROL TRAINING**
**Introduced by American College of Surgeons, American Academy of Facial Plastic and Reconstructive Surgery, American Association of Neurological Surgeons, Congress of Neurological Surgeons, North American Spine Society, American College of Emergency Physicians**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-130.935*

RESOLVED, That our American Medical Association encourage state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control; and be it further

RESOLVED, That our AMA encourage, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.

**520. MEDICAL MARIJUANA USE IN WOMEN OF REPRODUCTIVE AGE**
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: REFERRED FOR DECISION**

RESOLVED, That our American Medical Association adopt the American College of Obstetrics and Gynecology Committee on Obstetric Practice’s policies on marijuana use during pregnancy and lactation, as follows:

1. Before and during pregnancy, all women should be asked about their use of tobacco, alcohol, other drugs (including marijuana), and medications used for nonmedical reasons.
2. Women reporting marijuana use should be counseled about concerns regarding potential adverse health consequences of use during pregnancy.
3. Women who are pregnant or contemplating pregnancy should be encouraged to avoid marijuana use.
4. Pregnant women or women contemplating pregnancy should be encouraged to avoid use of marijuana for medicinal purposes in favor of an alternative therapy for which there are better pregnancy-specific safety data.
5. There are insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding, and in the absence of such data, marijuana use is discouraged; and be it further

RESOLVED, That our AMA encourage continuing medical education for licensed physicians who certify patients to use medicinal marijuana, include training about the risks of marijuana on reproduction, pregnancy, and breastfeeding; and be it further

RESOLVED, That our AMA encourage physicians who certify patients to use medicinal marijuana counsel women and men of reproductive age on the risks that marijuana use has on reproduction, pregnancy, and breastfeeding; and be it further

RESOLVED, That our AMA encourage physicians who certify female patients to receive marijuana for medical use to assess their patients’ pregnancy status and contraceptive method at each visit; and be it further

RESOLVED, That our AMA request and recommend that appropriate scientific agencies proceed with necessary research on the health effects of medicinal marijuana.

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### 521. TRANSGENERATIONAL EFFECTS OF ENVIRONMENTAL TOXINS ON REPRODUCTIVE HEALTH
**Introduced by Young Physicians Section**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-135.926*

RESOLVED, That our American Medical Association encourage study of the transgenerational effects of environmental toxins on reproductive health and development.

### 522. GUIDELINES FOR PRESCRIBING OPIOID MEDICATIONS
**Introduced by South Carolina**

*Reference committee hearing: see report of Reference Committee E.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-120.947*

RESOLVED, That our American Medical Association work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications in long-term care facilities, in much the same way as is being done for hospice and palliative care.

### 601. CHILDCARE AT THE AMA MEETINGS
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-600.958*

RESOLVED, That our American Medical Association review best practices and initiate a three-year pilot of onsite childcare at AMA Annual and Interim Meetings of the House of Delegates and Sections beginning at the 2017 Annual Meeting, with a report back regarding utilization and its impact on participation at AMA meetings.

### 602. PROTECTION OF PHYSICIANS' PERSONAL INFORMATION
**Introduced by Washington**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: ADOPTED**
*See Policy D-275.953*

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards to standardize the publicly available data on the state medical boards' websites to protect the personal data of physicians to decrease the risk of identity theft.

**Resolution 603 was withdrawn.**

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**604. LAYMEN'S MEDICAL ADVICE POLICY**
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: NOT ADOPTED**

RESOLVED, That our American Medical Association support a public campaign to promote patient recognition that when seeking medical advice, they are best served through partnership with their personal physician.

**605. ETHNIC MEDICAL ASSOCIATION INVOLVEMENT IN THE AMA**
**Introduced by International Medical Graduates Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: ADOPTED**
*See Policy D-620.990*

RESOLVED, That our American Medical Association work with the ethnic medical associations to increase participation and involvement in the AMA; and be it further

RESOLVED, That our AMA work with these different ethnic societies to identify their unique needs in order to fully engage them in our organization.

**606. AMENDING AMERICAN MEDICAL ASSOCIATION MEETING POLICY**
**Introduced by Ohio**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: ADOPTED**
*See Policy G-600.130*

RESOLVED, That American Medical Association Policy G-600.130 be amended by deletion of the fourth item that states our AMA will reaffirm its well-established practice of returning to Hawaii every four to five years for the AMA House of Delegates Interim Meeting.

**607. A GUIDE TO SELECTING A PHYSICIAN-LED INTEGRATED SYSTEM**
**Introduced by Integrated Physician Practice Section**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: ADOPTED**
*See Policy D-160.926*

RESOLVED, That our American Medical Association, in collaboration with the Integrated Physician Practice Section and appropriate partners within the House of Medicine, accomplish the following by the 2017 Annual Meeting:

1. Develop a guide for physicians considering joining or aligning with a physician-led integrated system that addresses, but is not limited to the following:
   a. various models of integrated systems;
   b. metrics that help determine the extent to which an integrated system fulfills the definition of, and performs as, an integrated system;
   c. how to determine an organization's quality commitment/record;

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d. how to know if a particular system is the right fit;
e. what does a physician stand to gain/lose when joining such a system; and

2. The guide should also provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value based care

### 608. INCLUDING MEDICAL STUDENTS IN STEPS FORWARD™ TO PREVENT BURN OUT AND PROMOTE STEPS FORWARD™ IN MEDICAL SCHOOLS NATIONWIDE
**Introduced by Florida**

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-405.957*

RESOLVED, That our American Medical Association review relevant modules of the STEPS Forward™ Program and also identify validated student-focused, high quality resources for professional well-being, and that our AMA encourage the Medical Student Section (MSS) and Academic Physicians Section (APS) to promote these resources to medical students.

### 701. ONLINE ACCESS TO PRESCRIPTION DRUG FORMULARIES
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-125.979*

RESOLVED, That our American Medical Association promote the value of up-to-date and accurate online access to prescription drug formulary plans from all insurance providers nationwide; and be it further

RESOLVED, That our AMA support state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans; and be it further

RESOLVED, That our AMA reaffirm Policy H-125.979, which states that our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.

### 702. STUDY OF CURRENT TRENDS IN CLINICAL DOCUMENTATION
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-295.314*

RESOLVED, That our American Medical Association study the effectiveness of current graduate and undergraduate education training processes on clinical documentation.

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## 703. VOLUNTARY REPORTING OF COMPLICATIONS FROM MEDICAL TOURISM
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-450.937*

RESOLVED, That our American Medical Association support efforts that allow for the reporting and tracking of quality and safety issue associated with medical procedures performed abroad; and be it further

RESOLVED, That our AMA reaffirm Policy H-450.937, which states that patients should only be referred for medical care outside the United States to institutions that have been accredited by recognized international accrediting bodies.

## 704. STEM CELL TOURISM
**Introduced by Medical Student Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy H-460.896*

RESOLVED, That our AMA (1) encourage the study of appropriate guidance for physicians to use when advising patients who seek to engage in stem cell tourism and how to guide them in risk assessment; (2) encourage further research on stem cell tourism; and (3) urge physicians to educate themselves on these issues.

## 705. RETAIL HEALTH CLINICS
**Introduced by Washington**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association encourage the study of patient care delivery within retail health clinics to ensure patient safety; and be it further

RESOLVED, That our AMA encourage the study of, and pursue legislation to ensure the appropriate oversight of retail health clinics as an entity separate from an independent physician's practice and other health care facilities; and be it further

RESOLVED, That our AMA encourage the study of potential conflicts of interest where retail clinics are located within a store that includes a pharmacy as such co-locations could result in incentives to provide costly, unnecessary, inappropriate and uncoordinated health related services.

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### 706. CONFLICT OF INTEREST DISCLOSURE EXEMPTIONS FOR NON-REIMBURSED MEDICAL STAFF AND FACULTY
**Introduced by Illinois**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICIES H-225.955 AND H-235.970 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association House of Delegates adopt policy stipulating that conflict of interest disclosure information be eliminated from all re-credentialing activities for physicians who do not hold specified leadership, budgeting or purchasing-related positions or responsibilities within health care institutions.

### 707. MEDICARE AND INSURANCE TAKEBACK PROCEDURES
**Introduced by New York**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policies H-70.926 and H-320.943*

RESOLVED, That our American Medical Association advocate to ensure that when a patient hospitalization is retrospectively found not to meet criteria for inpatient admission, then the take back amount be only the difference between the cost of the admission and the cost of necessary observation for that patient stay; and be it further

RESOLVED, That our AMA advocate to ensure that, for any care provided to hospital patients who have Medicare, managed Medicare, or commercial insurance, hospitals have the option to rebill denied inpatient claims as outpatient claims, when a physician using clinical judgment makes a prospective decision to admit a patient who is later not found to meet admission criteria; and be it further

RESOLVED, That our AMA reaffirm Policy H-70.926, which provides that post-payment audits, post-payment downcodes and other similar requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less.

### 708. CLINICAL PATHWAYS
**Introduced by American Society of Clinical Oncology**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policies H-320.949, H-410.948 and H-410.953*

RESOLVED, That our American Medical Association support the development of transparent, collaboratively constructed clinical pathways that: (a) are implemented in ways that promote administrative efficiencies for both providers and payers; (b) promote access to evidence-based care for patients; (c) recognize medical variability among patients and individual patient autonomy; (d) promote access to clinical trials; and (e) are continuously updated to reflect the rapid development of new scientific knowledge; and be it further

RESOLVED, That our AMA reaffirm Policy H-320.949, which establishes that clinical practice guidelines, when used by health plans, must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care; and be it further

RESOLVED, RESOLVED, That our AMA reaffirm Policy H-410.953, which requires formal procedures to be adopted to minimize the potential for undue financial or other interests from influencing the development of clinical guidelines.

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**709. REIMBURSEMENT FOR DISTINCT SERVICES**
**Introduced by Michigan**

*Considered on reaffirmation calendar.*

**HOUSE ACTION: POLICY H-390.888 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to ensure that all valid claims for distinct services submitted under the same tax identification number (TIN) or by providers within the same specialty on the same day be reimbursed fairly without regard to the TIN or specialty designation.

**710. ELIMINATE THE REQUIREMENT OF "H&P UPDATE"**
**Introduced by Ohio**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association work to change Centers for Medicare & Medicaid Services' Medicare requirements for the "H&P Update" as follows:

A. Change policy 482.24 (c)(4)(i)(B) to read as follows:
When the medical history and physical examination are completed within thirty days before admission or registration, documentation of an updated examination of the patient must be placed in the patient's medical record within twenty-four hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, only if any changes have occurred in the patient's condition.

B. Change policy 482.51 (b)(1)(ii) to read as follows:

When the medical history and physical examination are completed within thirty days prior to admission or registration, an updated examination of the patient must be completed and documented within twenty-four hours of admission or registration only if any changes have occurred in the patient's condition.

**711. ACCURATE MENTAL STATUS REPORTING**
**Introduced by AMDA-The Society for Post-Acute and Long-Term Care Medicine**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-345.986*

RESOLVED, That our American Medical Association encourage interested national medical specialty societies to develop recommendations regarding mental status information that should be transmitted when patients transition care settings.

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**712. REMOVE PRICING BARRIERS TO TREATMENT FOR HEPATITIS C (HCV)**
**Introduced by New Mexico**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association advocate with Congress and federal agencies, for any necessary combination of legislation, regulation, negotiation with the pharmaceutical industry, and federal subsidies, to lower the cost of treatment for all Americans infected with Hepatitis C virus using highly effective oral medications, to a price level that would make treatment affordable and accessible.

**713. MEDICAL STAFF ENGAGEMENT AT CRITICAL ACCESS HOSPITALS**
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED**
*See Policy H-225.944*

RESOLVED, That our American Medical Association encourage all MD/DO(s) on staff at Critical Access Hospitals to contribute to the quality and safety of care provided in those organizations by participating in medical staff activities, including but not limited to credentialing and privileging activities.

**714. MIXED MEDICAL STAFFS**
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED**
*See Policy H-225.943*

RESOLVED, That our American Medical Association affirm its unyielding support for the principle that the members of the organized medical staff must work collectively to improve patient care and outcomes, regardless of the employment status or practice setting of each individual member; and be it further

RESOLVED, That our AMA, through its Organized Medical Staff Section and other appropriate channels, provide guidance to medical staffs, including but not limited to effective medical staff leadership strategies and relevant updates to the *AMA Physician's Guide to Medical Staff Organization Bylaws*, that facilitate representation of and encourage participation in medical staff activities by community-based and independent physicians.

**715. CMS EMERGENCY DEPARTMENT PATIENT EXPERIENCE OF CARE SURVEY (EDPEC)**
**Introduced by Organized Medical Staff Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED**
*See Policy H-450.929*

RESOLVED, That our American Medical Association monitor the development of the Centers for Medicare and Medicaid Services' Emergency Department Patient Experience of Care (EDPEC) Survey and advocate for fair and reliable reporting that accurately reflects the quality of care provided by physicians and/or hospitals.

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## 716. MITIGATING ABUSIVE PRE-CERTIFICATION/PRE-AUTHORIZATION PRACTICES
**Introduced by Resident and Fellow Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: ADOPTED AS FOLLOWS**
*See Policy D-310.951*

RESOLVED, that our American Medical Association work with the Accreditation Council for Graduate Medical Education to encourage residency programs to offer administrative resources to housestaff for practice-based support, including but not limited to pre-certification and pre-authorization of medications and services.

## 717. UNFORESEEN CONSEQUENCES OF CORE MEASURES
**Introduced by Young Physicians Section**

*Reference committee hearing: see report of Reference Committee G.*

**HOUSE ACTION: REFERRED**

RESOLVED, That our American Medical Association call for the immediate suspension of the SEP-1 core measure and any financial incentives or penalties relating to compliance with it; and be it further

RESOLVED, That our AMA strongly discourage the implementation of further protocols, core measures, or directives concerning the care of patients in the outpatient or inpatient setting without structured trials designed to identify unforeseen costs and potential patient harms; and be it further

RESOLVED, That our AMA strongly discourage the implementation of indiscriminant and not medically indicated screening or testing for “pre-existing” infection in patients in order to avoid financial penalties; and be it further

RESOLVED, That our AMA support any physician who refuses to perform testing or treatment that they feel is not medically indicated or potentially harmful to patients.

## LATE 1010. FIXING THE VA PHYSICIAN SHORTAGE WITH PHYSICIANS
**Introduced by Melissa J. Garretson, MD, Delegate; David A. Rosman, MD, Delegate; Arizona, Colorado, Connecticut, Idaho, Maine, Massachusetts, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Rhode Island, Texas, Utah, Vermont, Wyoming, Young Physicians Section**

*No reference committee hearing; considered as a committee of the whole.*

**HOUSE ACTION: ADOPTED AS FOLLOWS
AND FOURTH RESOLVE REFERRED**
*See Policy D-510.990*

RESOLVED, That our American Medical Association work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities; and be it further

RESOLVED, That our AMA call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility; and be it further

RESOLVED, That our AMA work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.

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Note: The following resolve was referred for report:

RESOLVED, That our AMA advocate that the VA be funded to pay physicians (at or above the prevailing rate in their communities) (adequately to encourage recruitment).

At the time of referral, debate concerned an amendment to replace the first parenthesized expression with the second parenthesized expression.

## LATE 1011. GUN VIOLENCE AS A PUBLIC HEALTH CRISIS

**Introduced by Joshua M. Cohen, MD, Delegate; Alaska, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Association of Public Health Physicians, American Clinical Neurophysiology Society, American College of Emergency Physicians, American College of Physicians, American College of Preventive Medicine, American College of Surgeons, American Congress of Obstetricians and Gynecologists, American Geriatrics Society, American Psychiatric Association, American Society of Addiction Medicine, American Society of Anesthesiologists, American Society of Clinical Pathology, American Society of Cytopathology, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, GLMA, Guam, Hawaii, Idaho, Illinois, International Medical Graduates Section, Iowa, Kansas, Maine, Maryland, Massachusetts, Medical Student Section, Michigan, Minnesota, Minority Affairs Section, Missouri, National Association of Medical Examiners, National Medical Association, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Resident and Fellow Section, Rhode Island, Section Council on Psychiatry, Senior Physicians Section, Society for Investigative Dermatology, South Dakota, Utah, Vermont, Virginia, Washington, Wisconsin, Women Physicians Section, Wyoming, Young Physicians Section**

*No reference committee hearing; considered as a committee of the whole.*

**HOUSE ACTION: ADOPTED**
*See Policy D-145.995*

RESOLVED, That our American Medical Association immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and be it further

RESOLVED, That our AMA actively lobby Congress to lift the gun violence research ban.

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