MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY

Donald W. Fisher, PhD, CAE
Introduced by the American Medical Group Association

Whereas, Donald W. Fisher, PhD, CAE, American Medical Group Association president and chief executive officer, passed away on March 26, 2017; and

Whereas, Dr. Fisher has been at the helm of AMGA since 1980, leading it to become the voice of multispecialty medical groups and integrated systems of care; and

Whereas Dr. Fisher had a personal impact on American health care as a strong advocate for coordinated, integrated delivery systems, working to make his vision of superior care a reality; and

Whereas, Dr. Fisher earned recognition of group practice care as a specialty by AMA and thereby gained AMGA a seat in the AMA House of Delegates; and

Whereas, Dr. Fisher earned a BS in biology/chemistry from Millsaps College in 1968, his MS in anatomy from the University of Mississippi, School of Medicine in 1971 and a PhD in anatomy from the University of Mississippi in 1973. His passion was health care, and he served on numerous related boards and councils as well as received many honors, including the Russell V. Lee Lectureship and the Presidential Award from the American Academy of Physician Assistants; and

Whereas Dr. Fisher's passion for health care and improving the lives of patients were rivaled only by his dedication, humor, and intellect; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Dr. Fisher's dedication to advancing the best possible patient care, to leading with integrity; and be it further

RESOLVED, That our AMA House of Delegates extend its deepest sympathy to the family members of Donald W. Fisher, PhD, CAE.

Virginia "Ginger" Tullis Latham, MD
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Senior Physicians Section

Whereas, Virginia "Ginger" Tullis Latham, MD, was born on May 28, 1940, and passed away on April 21, 2017; and

Whereas, Dr. Latham resided in Harvard, MA, where she lived with her beloved husband, David W. Latham, Sr., with whom she shared 57 years of marriage. Ginger, who had a great love of learning, graduated from Beaver Country Day School in Chestnut Hill, MA and then went on to Duke University as a Honorary Duke National Scholar. She graduated from Boston University. After raising 5 sons, Ginger enrolled in Harvard Medical School and completed her residency in Internal Medicine in 1981; and

Whereas, Dr. Latham was a well-respected and beloved member of the Emerson Hospital community; and

Whereas, Dr. Latham took great pleasure in leadership roles for Harvard town activities including the local Garden Club Board, the Harvard Woman's Club (HWC) and a weekly bridge group of the HWC in conjunction with the Harvard Committee on Aging; and

Whereas, Dr. Latham has been a member of the Massachusetts Medical Society (MMS) and the Middlesex Central District Medical Society for over 30 years; and

Whereas, Dr. Latham was president of the Massachusetts Medical Society in 2000 and was the third female to become president in MMS history; and

Whereas, Under Dr. Latham's presidency, the Society made its mark in the area of patient safety, with the passage of the landmark Patient Bill of Rights, as well as providing strong support for patient privacy and confidentiality, as new regulations in the Health Insurance Portability and Accountability Act came into being. She also co-chaired the search committee for a new editor for the New England Journal of Medicine--an activity that resulted in the appointment of the current editor, Dr. Jeffrey Drazen; and

Whereas, Dr. Latham was a member of many MMS committees, including Strategic Planning, Senior Physicians, Women Physicians, Judicial, Finance, Board of Trustees, Medical Student Debt Reduction, and the House of Delegates, to name a few; and

Whereas, Dr. Latham was a member of the MMS's American Medical Association's Delegation for many years; and

Whereas, Dr. Latham was a member of the AMA Senior Physicians Group Governing Council and a driving force in its becoming a Section of AMA House of Delegates with a voting seat, always striving, as she had throughout her career, for a voice for physicians (of all ages) to be advocates for the patients for whom they care; and

Whereas, Dr. Latham was honored at the 2016 Interim Meeting of the MMS House of Delegates with a Presidential Citation in recognition of a career in medicine exemplary of the highest traditions, ideals, and aspirations of the MMS; therefore be it

RESOLVED, That our American Medical Association note with great sadness the passing of Virginia Tullis Latham, MD, with thankfulness and gratitude for the gift of her life and work; and be it further

RESOLVED, That expressions of condolence be forwarded with a copy of this memorial resolution to the Latham family.

Jerry McLaughlin, II, MD
Introduced by New Mexico and Texas

Whereas, Dr. Jerry McLaughlin, a dedicated Obstetrician and Gynecologist who delivered over 6,000 babies and touched countless lives, was greatly revered by his patients, fellow physicians and all those for whom he cared and with whom he worked; and

Whereas, Dr. Jerry McLaughlin was an active and giving member of the communities in which he lived, and greatly beloved by his wife, children and extended family; and

Whereas, Dr. Jerry McLaughlin was a tireless and eloquent advocate for organized medicine and our profession, and an inspiration and mentor for medical students, residents and young physicians, many of whom developed a love of organized medicine under his gentle tutelage; and

Whereas, Dr. Jerry McLaughlin represented the physicians of New Mexico and Texas with distinction on the national stage over the decades of his medical career, in roles including: Delegate to the AMA Young Physician's Section, Alternate Delegate to the AMA House of Delegates from both New Mexico and Texas, Delegate to the AMA House of Delegates from New Mexico, Chairman and Member of multiple AMA Reference Committees including Reference Committee F, and member of the Governing Council of the United States Pharmacopoeia; and

Whereas, Dr. Jerry McLaughlin honorably served the New Mexico Medical Society in roles including: Vice speaker, President, Councilor, Executive Council Member, New Mexico Medical PAC Member, Special Lecturer, and member of various liaison committees; and

Whereas, Dr. Jerry McLaughlin also served his local New Mexico community as both Lea County Medical Society Member and President; and

Whereas, When Dr. McLaughlin left New Mexico for a new opportunity in Texas, the New Mexico Medical Society commissioned the "Jerry McLaughlin Service Award," to recognize outstanding and lasting commitment to the Medical Society and the community, to be awarded in perpetuity to deserving NMMS members; and

Whereas, Dr. Jerry McLaughlin was one of the very few people in this world who could pull off wearing a red blazer and red cowboy boots for dress-up clothes; and

Whereas, Dr. Jerry McLaughlin's tragic and untimely death on January 20, 2017 was devastating for all those who knew and loved him; therefore be it

RESOLVED, That the House of Delegates of our American Medical Association rise in appreciation and remembrance of our esteemed and distinguished colleague and friend, Jerry Dewayne McLaughlin II, MD.

Joseph Thomas Painter, MD
Introduced by Texas

Whereas, Joseph Thomas Painter, MD, a Houston internist, cardiologist, and professor, passed away on Jan. 4, 2017; and

Whereas, Dr. Painter practiced medicine for 21 years after graduating as valedictorian of his medical class at The University of Texas Medical Branch at Galveston in 1949 and completing his internship and residency at the Hospital of the University of Pennsylvania in 1954, which he interrupted to serve as a captain in the United States Air Force during the Korean War; and

Whereas, He then became a professor of clinical medicine and vice president of The University of Texas MD Anderson Cancer Center, where he served in multiple administrative roles until his retirement in 1994; and

Whereas, He served as president of the American Society of Internal Medicine from 1970 to 1971, chair of the American Medical Association from 1990 to 1992, president of the American Medical Association from 1993 to 1994, and chair of the World Medical Association Council from 1993 to 1995; and

Whereas, Dr. Painter received the Ashbel Smith Distinguished Alumnus Award in 1985 from The University of Texas Medical Branch at Galveston, the Distinguished Alumnus Award in 1994 from The University of Texas at Austin, and the Distinguished Service Award in 1994 from The University of Texas MD Anderson Cancer Center; and

Whereas, Dr. Painter was an exceptional example to his children and grandchildren of the value of honesty, perseverance, generosity, loyalty, and devotion, while also being a consummate gentleman who treated others with the utmost dignity and respect; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Joseph Thomas Painter, MD, for outstanding service to the profession of medicine and his patients; and be it further

RESOLVED, That our AMA House of Delegates extend its deepest sympathy to the family members of Joseph Thomas Painter, MD.

Richert E. Quinn, MD
Introduced by Colorado

Whereas, Richert E. Quinn Jr., MD, passed away January 11, 2017 at the age of 75. Quinn was a loving husband, father and grandfather; a respected general surgeon in Greeley who was instrumental in establishing and then leading the burn unit at the Weld County Hospital; a leader in the American Medical Association, Colorado Medical Society, Weld County Medical Society and Northern Colorado Medical Society; and a visionary who helped establish COPIC Insurance Company (COPIC) and contribute to its tremendous success; and

Whereas, "Dr. Richert Quinn really believed in and embodied that we were part of a profession," said Alan Lembitz, MD, COPIC's chief medical officer, who got to know Quinn as a resident physician. "He taught that we had a special role and responsibility to our patients, but he also led by example that we as physicians had a duty to each other to make this profession of medicine better. Rich worked tirelessly in the 'house of medicine,' but also was just as dedicated one on one in what today we call mentoring"; and

Whereas, "Never at a loss for words, nor short of an opinion, Rich got things done sometimes by sheer force of will," Lembitz continued. "I enjoyed his big heart, his self-deprecating sense of humor and his devotion to others. 'If I see further today it is only because I stand on the shoulders of giants' might seem like an odd hyperbole for this setting, but to me it defines what made Rich Quinn's contributions and attitude special to our profession. He was a wise and good soul, and he will be missed"; and

Whereas, Quinn served as CMS president in 1985-1986 and was elected a delegate to the AMA in 1986. CMS President-elect M. Robert Yakely, MD, was chairman of the CMS Council on Legislation during Quinn's tenure as CMS president. "During that period we worked together closely on getting legislation on tort reform that has continued to protect Colorado physicians to this day. Rich was a leader in this effort and a visionary for our society in this area. He saw the need to form coalitions with other interested parties. It took several years to develop this coalition, but he never wavered in his effort to achieve this milestone goal much to the benefit of all the physicians of Colorado"; and

Whereas, "Through his leadership and direction the delegation to the AMA was able to pass many strategic resolutions and elect numerous delegates' important positions within the AMA," said Ray Painter, MD, past president of CMS and a leader of the Colorado delegation to the AMA. "Dr. Quinn was a very trusted friend to many and liked by all for his commitment, humility and sense of humor"; and

Whereas, AMA Past President Jeremy Lazarus, MD, calls Quinn a true friend and mentor who was "unassuming, humble, tactically astute and collegial in a very special way." Quinn helped Lazarus gain the experience needed to run for AMA office and then helped him achieve that office. "He led our AMA delegation with great dignity and was a trailblazer when he was elected to the AMA's Council on Constitution and Bylaws. He went on to chair that council with the same solid performance that he had always shown," Lazarus said; and

Whereas, Quinn joined the COPIC board in 1986 and served for nearly 10 years before stepping off to become the vice president of COPIC's Risk Management Department. Jerry Buckley, MD, past chairman and CEO of COPIC, credits Quinn with "raising the bar of patient safety and quality to such a degree in Colorado that it was considered the gold standard of medical liability insurance companies not only in the United States but worldwide"; and

Whereas, "Rich was the consummate risk manager, equally concerned for both the patient and the physician provider in any medical intervention," Buckley continued. "His unique style of first telling you all the things you did correct captured your attention so you would be totally open to learn from what did not go as you anticipated. His love of medicine was only exceeded by his love for his wife, Carol, and children, Kevin and Shannon, and their beautiful children," Buckley said. "I loved him, his sense of humor and have no one to replace his special charm"; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize and commend Dr. Richert E. Quinn's life of service to all who knew him; and be it further

RESOLVED, That our AMA House of Delegates extend its deepest sympathy to the family of Richert E. Quinn, MD.

Richert E. Quinn, Jr., MD
Introduced by Senior Physicians Section

Whereas, Dr. Richert "Rich" Edward Quinn, Jr., MD, a Greeley, Colorado surgeon, passed away on January 11, 2017; and

Whereas, Dr. Quinn graduated from the University of Missouri in Columbia, and completed a surgical residency at St. Joseph Hospital in Denver; and

Whereas, Following his education he moved to Greeley, Colorado, where he practiced at the Greeley Medical Clinic for the next two decades and cared for hundreds of patients; and

Whereas, During his extensive surgical career, he spent time as the Medical Director for the Greeley Medical Clinic, and was named Chair of the Department of Surgery at North Colorado Medical Center, and later served as Director of the Burn Unit at NCMC, a specialized care center he helped to create; and

Whereas, Dr. Quinn was elected to the AMA House of Delegates, serving from 1985 to 2011, and the AMA Senior Physicians Section from 2009 to 2014, serving as Chair his last year; and

Whereas, Dr. Quinn's knowledge of AMA issues and his quiet, effective manner led to a high degree of respect in our AMA House of Delegates; and

Whereas, Dr. Quinn became a valued member of the AMA Council on Constitution and Bylaws, ultimately serving as chair of that council; and

Whereas, Dr. Quinn was a key figure in the development and recognition of our AMA Senior Physicians Section; and

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

RESOLVED, That our American Medical Association House of Delegates recognize Doctor Richert E. Quinn's outstanding service to the profession; and be it further

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

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 11. The following resolutions were handled on the reaffirmation calendar: 5, 102, 104, 105, 113, 122, 202, 221, 232, 234, 509, 512, 519, 704 and 710.

1. PARTICIPATION OF PHYSICIANS ON HEALTHCARE ORGANIZATION BOARDS
Introduced by Pennsylvania

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-405.990

RESOLVED, That our American Medical Association advocate for and promote the membership of physicians on the boards of healthcare organizations including, but not limited to, acute care providers, insurance entities, medical device manufacturers and health technology service organizations; and be it further

RESOLVED, That our AMA promote educational programs on corporate governance that prepare and enable physicians to participate on health organization boards; and be it further

RESOLVED, That our AMA provide physicians, the public and health care organizations information on the positive impact of physician leadership.

2. CARE OF WOMEN AND CHILDREN IN FAMILY IMMIGRATION DETENTION
Introduced by Women Physicians Section

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-350.955

RESOLVED, That our American Medical Association recognize the negative health consequences of the detention of families seeking safe haven; and be it further

RESOLVED, That due to the negative health consequences of detention, our AMA oppose the expansion of family immigration detention in the United States; and be it further

RESOLVED, That our AMA oppose the separation of parents from their children who are detained while seeking safe haven; and be it further

RESOLVED, That our AMA advocate for access to health care for women and children in immigration detention.

3. MEDICAL SPECTRUM OF GENDER
Introduced by New York

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-295.312

RESOLVED, That our American Medical Association work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity.

Resolution 4 was moved to Reference Committee D. See Resolution 418.

5. PERIOPERATIVE DO NOT RESUSCITATE ORDERS
Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: ETHICAL OPINION E-5.4, ORDERS NOT TO ATTEMPT RESUSCITATION (DNAR), REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association adopt as policy the "required reconsideration" of patients' existing advance directives in the perioperative period, in order to support the review of a patient's advance directive prior to the performance of a procedure/surgery and the administration of anesthesia.

6. INCREASING ACCESS TO HEALTHCARE INSURANCE FOR REFUGEE POPULATIONS
Introduced by Medical Student Section

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

HOUSE ACTION: ADOPTED
See Policy H-350.956

RESOLVED, That our American Medical Association support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.

7. HEALTHCARE AS A HUMAN RIGHT
Introduced by Minority Affairs Section

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

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association recognize that a basic level of medical care is a fundamental human right; and be it further

RESOLVED, That our AMA support the United Nations' Universal Declaration of Human Rights and its encompassing International Bill of Human Rights as guiding principles fundamental to the betterment of public health; and be it further

RESOLVED That our AMA advocate for the United States to remain a member state in the World Health Organization.

8. PROMOTING THE USE OF APPROPRIATE LGBTQIA LANGUAGE IN MEDICAL DOCUMENTATION
Introduced by California

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

HOUSE ACTION: POLICY H-315.967 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support the inclusion of a patient's biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and (if applicable), surrogate identifications in medical documentation and related forms in a culturally-sensitive manner.

9. COMMERCIAL EXPLOITATION AND HUMAN TRAFFICKING OF MINORS
Introduced by California

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

HOUSE ACTION: ADOPTED
See Policy H-60.912

RESOLVED, That our American Medical Association support the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

10. ACCESS TO BASIC HUMAN SERVICES FOR TRANSGENDER INDIVIDUALS
Introduced by GLMA

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

HOUSE ACTION: ADOPTED
See Policy H-65.964

RESOLVED, That our American Medical Association oppose policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and be it further

RESOLVED, That our AMA advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

11. REVISION OF RESEARCHER CERTIFICATION AND INSTITUTIONAL REVIEW BOARD (IRB) PROTOCOLS
Introduced by Florida

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

HOUSE ACTION: REFERRED

RESOLVED, Our American Medical Association study existing Collaborative Institutional Training Initiative standards, Institutional Review Board protocols and create recommendations that would simultaneously protect patients and permit physicians to easily participate in the dissemination of medical knowledge; and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2017 Interim Meeting.

12. PROMOTING THE AMA MODEL MEDICAL STAFF CODE OF CONDUCT AND ITS APPLICATION TO EMPLOYED PHYSICIANS
Introduced by American Association of Neurological Surgeons and Congress of Neurological Surgeons

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-230.985

RESOLVED, That our American Medical Association actively educate state and specialty medical societies about the AMA Medical Staff Code of Conduct and promote its use; and be it further

RESOLVED, That our AMA advocate for the separation between the terms of employment contracts and medical staff privileges. This separation includes an ongoing right of review for all physicians regardless of employment status with the organization. This right of review may include a physician's good faith conduct that has been characterized as "disruptive, intimidating or inappropriate."

13. GENDER IDENTITY INCLUSION AND ACCOUNTABILITY IN REMS
Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery Association, American College of Mohs Surgery, American Society of Dermatopathology, GLMA, Society for Investigative Dermatology, Wisconsin

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

HOUSE ACTION: ADOPTED
See Policy D-100.968

RESOLVED, That our American Medical Association work with the United States Food and Drug Administration to develop a gender-neutral patient categorization model in Risk Evaluation and Mitigation Strategies programs, focusing exclusively on childbearing potential rather than gender identity.

14. THE NEED TO DISTINGUISH BETWEEN 'PHYSICIAN ASSISTED SUICIDE' AND 'AID IN DYING'
Introduced by M. Zuhdi Jasser, MD, Delegate

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

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association, as a matter of organizational policy, when referring to what it currently defines as 'Physician Assisted Suicide' avoid any replacement with the phrase 'Aid in Dying' when describing what has long been understood by the AMA to specifically be 'Physician Assisted Suicide'; and be it further

RESOLVED, That our AMA develop definitions and a clear distinction between what is meant when the AMA uses the phrase 'Physician Assisted Suicide' and the phrase 'Aid in Dying'; and be it further

RESOLVED, That these definitions and distinction be fully utilized by our AMA in organizational policy, discussions, and position statements regarding both 'Physician Assisted Suicide' and 'Aid in Dying.'

15. APPROPRIATE PLACEMENT OF TRANSGENDER PRISONERS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

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

HOUSE ACTION: REFERRED

RESOLVED That our American Medical Association establish policy supporting the ability of transgender prisoners to be placed in facilities that are reflective of their affirmed gender status regardless of surgical status, if they so choose.

16. CONSIDERATION OF THE HEALTH AND WELFARE OF U.S. MINOR CHILDREN IN DEPORTATION PROCEEDINGS AGAINST THEIR UNDOCUMENTED PARENTS
Introduced by Young Physicians Section

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

HOUSE ACTION: ADOPTED
See Policy D-60.966

RESOLVED, That our American Medical Association support that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported; and be it further

RESOLVED, That our AMA work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation.

17. IMPROVING MEDICAL CARE IN IMMIGRANT DETENTION CENTERS
Introduced by Medical Student Section

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

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-350.983

RESOLVED, That our American Medical Association issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) track complaints related to substandard healthcare quality; and be it further

RESOLVED, That our AMA recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and be it further

RESOLVED, That our AMA advocate for access to health care for individuals in immigration detention.

18. PATIENT AND PHYSICIAN RIGHTS REGARDING IMMIGRATION STATUS
Introduced by Medical Student Section

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

HOUSE ACTION: ADOPTED
See Policy H-315.966

RESOLVED, That our American Medical Association support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

19. OWNERSHIP OF PATIENT DATA
Introduced by Organized Medical Staff Section

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

HOUSE ACTION: ADOPTED WITH CHANGE IN TITLE
See Policy D-315.976

RESOLVED, That our American Medical Association undertake a study of the use and misuse of patient information by hospitals, corporations, insurance companies, or big pharma, including the impact on patient safety, quality of care, and access to care when a patient's data is withheld from his or her physician, with report back at the 2018 Annual Meeting.

20. RECOGNITION OF PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) FORMS
Introduced by Organized Medical Staff Section

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

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate with appropriate government, legislative and regulatory bodies to recognize Physician Orders for Life Sustaining Treatment forms completed in one state as valid and enforceable in other states; and be it further

RESOLVED, That our AMA create a universal Physician Orders for Life Sustaining Treatment form that would be valid and enforceable in all states.

101. ELIMINATING FINANCIAL BARRIERS FOR EVIDENCE-BASED HIV PRE-EXPOSURE PROPHYLAXIS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-20.895

RESOLVED, That our American Medical Association amend Policy H-20.895 by addition to read as follows:

H-20.895, Pre-Exposure Prophylaxis (PrEP) for HIV
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

102. ESTABLISHING A MARKET SYSTEM OF HEALTH SYSTEM FINANCING AND DELIVERY
Introduced by Louisiana

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-373.998 REAFFIRMED

RESOLVED, That our American Medical Association reaffirm current Policy H-373.998, Patient Information and Choice.

103. BENEFIT PAYMENT SCHEDULE
Introduced by Louisiana

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICY H-385.987 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association adopt as policy the following definition: a Benefit Payment Schedule plan is a type of health insurance in which the insurer makes a payment for covered services according to a schedule of benefits, the physician, hospital or other provider charges a fee for those services and it is up to the patient and the provider to determine what to do about any difference between the fee and the payment; and be it further

RESOLVED, That our AMA support the inclusion of Benefit Payment Schedule plans as one option in a pluralistic system of health care financing.

104. CONSULTATION CODE REINSTATEMENT
Introduced by Louisiana

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-70.953 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to reinstate in the Medicare fee schedule the AMA's CPT codes for consultation for the purposes of enhancing communication among providers, allowing the tracking of patients seen on consultation from other providers, sending of information about the evaluation and recommended management of these patients to those providers thereby increasing collaboration and coordination of care by the consulting providers with resulting improved quality of care and compliance with treatment recommendations.

105. OPPOSITION TO PRICE CONTROLS
Introduced by Louisiana

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-155.962 AND H-373.998 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm our continued opposition to the use of price controls in any segment of the health care industry, and continue to promote market-based strategies to achieve access to and affordability of health care goods and services.

106. MEDICAL LOSS RATIO
Introduced by Louisiana

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-155.959, H-320.968 AND D-155.993 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage medical insurance companies to change the term "Medical Loss Ratio" to "Medical Benefit Ratio" and that insurance companies define the elements comprising the "Medical Benefit Ratio"; and be it further

RESOLVED, That our AMA advocate that in the interest of full transparency, health financing plans, including insurance, prepaid care and value based payment models, should be required to publish their Medical Benefit Ratios.

107. STUDYING MECHANISMS, INCLUDING A PUBLIC OPTION, TO IMPROVE HEALTH INSURANCE MARKETPLACE AFFORDABILITY, COMPETITION AND STATILIZATION

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ALTERNATIVE RESOLUTION 107 ADOPTED
See Policy D-165.934

RESOLVED, That our American Medical Association study mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and be it further

RESOLVED, That our AMA study the feasibility of a public option insurance plan as a model as part of a pluralistic health care delivery system to improve access to care.

108. OUT-OF-NETWORK CARE

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ALTERNATIVE RESOLUTION 108 ADOPTED
IN LIEU OF RESOLUTIONS 108, 115, 118 AND 127
See Policies H-165.839, H-285.904, H-285.908, H-285.911 and H-373.998 and D-285.962

RESOLVED, That our AMA reaffirm Policies H-165.839, H-373.998, H-285.911 and H-285.908; and be it further

RESOLVED, That our AMA adopt the following principles related to unanticipated out-of-network care:

1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
7. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standard should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
8. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g., the Gould Criteria) are not accounted for within a minimum coverage standard; and be it further

RESOLVED, That our AMA develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care.

109. SIMPLIFY MEDICARE FACE TO FACE REQUIREMENT
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICY D-330.914 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate to simplify the Medicare requirements for a "Face to Face" visit with a patient by a physician as a precondition for Medicare home health coverage, including advocating for alternatives for such "Face to Face" visit such as by telehealth.

110. OVER-THE-COUNTER CONTRACEPTIVE DRUG ACCESS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association condemn age-based, cost-based, and other non-medical barriers to contraceptive drug access; and be it further

RESOLVED, That our AMA adopt policy supporting equitable access to over-the-counter (OTC) contraception, including those forms of contraception recommended for OTC sale, patient risk assessment screening tools, and prescribing by non-physicians; and be it further

RESOLVED, That our AMA support policy solutions that prohibit cost-sharing obstacles to OTC contraceptive drug access, and full coverage of all contraception without regard to prescription or OTC utilization, since all contraception is essential preventive health care; and be it further

RESOLVED, That our AMA advocate for the legislative and/or regulatory mechanisms needed to achieve improvements for OTC contraceptive drug access and quality.

111. VA TECHNOLOGY-BASED EYE CARE SERVICES
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-480.946 and H-510.982

RESOLVED, That our American Medical Association encourage the Department of Veterans Affairs to continue to explore telemedicine approaches that increase access to quality health care to U.S. Veterans, including the Technology-Based Eye Care Services (TECS) program; and be it further

RESOLVED, That our AMA work with Congress to ensure that U.S. Veterans can access eye care through the Technology-Based Eye Care Services (TECS) program; and be it further

RESOLVED, That our AMA reaffirm Policy H-480.946.

112. CMS MUST PUBLISH ALL VALUES FOR NON-COVERED AND BUNDLED SERVICES
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-400.944

RESOLVED, That our American Medical Association advocate that the Centers for Medicare and Medicaid Services must publish the RUC recommended values for ALL services, including non-covered and bundled services.

113. THE AMA WILL SUPPORT PAYMENT PARITY AT MEDICARE LEVELS FOR ALL MEDICAID SERVICES
Introduced by American Academy of Pediatrics

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-290.965, H-290.976 AND H-290.980 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support fair payment equity for all Medicaid providers at Medicare rates to assure that all Medicaid patients have access to a medical home and affordable, timely access to primary and specialty care services.

114. COVERAGE FOR PREVENTIVE CARE AND IMMUNIZATIONS
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-185.924

RESOLVED, That our American Medical Association advocate that all public and private payers be required to provide first dollar coverage of routine preventive pediatric care, as recommended by the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP), and immunizations, as recommended by the Centers for Disease Control and Prevention, AAP and AAFP.

115. OUT-OF-NETWORK CARE
Introduced by American College of Emergency Physicians, American Academy of Orthopaedic Surgeons, American College of Radiology, American Society of Anesthesiologists, College of American Pathologists, American Association of Neurological Surgeons, Congress of Neurological Surgeons, Colorado, Georgia, Pennsylvania, Washington, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Resolution 115 was considered with resolutions 108, 118 and 127. See Resolution 108.

RESOLVED, That our American Medical Association adopt the following principles related to unexpected out-of-network care:

1. Patients should not be financially penalized for receiving unexpected care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should uphold such standards in approving health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived Medicare rate or a rate completely under the control of the insurance company.
7. In lieu of balance or surprise billing of patients, an appropriate and fair minimum benefit standard for unexpected out-of-network services should be created. The minimum benefit standard should accurately reflect reasonable physician charges, such as through the establishment of a charge-based reimbursement schedule connected to an independently recognized and verified database that is geographically specific, completely transparent, and independent of the control of either payers or providers; and be it further

RESOLVED, That our AMA reaffirm Policies H-185.939, H-450.941, and D-285.972.

116. MEDICARE ADVANTAGE PLANS
Introduced by California

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policies H-330.878 and D-330.923

RESOLVED, That our American Medical Association support that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts; and be it further

RESOLVED, That our AMA reaffirm Policy D-330.923, which encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs to those health plans where physician payment rates are no less than Medicare Fee for Service rates.

117. EXPANSION OF U.S. VETERANS' HEALTHCARE CHOICES
Introduced by Ohio

Resolution 117 was considered with Council on Medical Service Report 6, which was adopted in lieu of following resolution. See Council on Medical Service Report 6

RESOLVED, That our American Medical Association adopt as 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 mechanisms such 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 expansion of healthcare choices for Veterans Administration eligible veterans.

118. THIRD PARTY PATIENT REIMBURSEMENT FOR OUT-OF-NETWORK PHYSICIANS
Introduced by Ohio

Resolution 118 was considered with resolutions 108, 115 and 127. See Resolution 108.

RESOLVED, That our American Medical Association policy seek to require insurers and third-party payers to properly reimburse patients and/or out-of-network physicians their usual charges, and that there be no increase in deductibles or co-payments for those patients requiring care from out-of-network physicians because of urgent and emergent treatment needed in emergency rooms and hospitals and/or seek federal legislation addressing these issues.

119. SUPPORT EFFORTS TO IMPROVE ACCESS TO DIABETES SELF-MANAGEMENT TRAINING SERVICES
Introduced by Endocrine Society, Obesity Medicine Association, American Association of Clinical Endocrinologists

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-160.899

RESOLVED, That our American Medical Association actively support regulatory and legislative actions that will mitigate barriers to Diabetes Self-Management Training (DSMT) utilization; and be it further

RESOLVED, That our AMA support outreach efforts to foster increased reliance on DSMT by physician practices in order to improve quality of diabetes care.

120. NATIONAL PRESSURE ULCER ADVISORY PANEL RECOMMENDATION FOR PRESSURE ULCER NOMENCLATURE CHANGE
Introduced by AMDA-The Society for Post-Acute and Long-Term Care Medicine

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-70.913

RESOLVED, That our American Medical Association formally oppose a change in nomenclature from “pressure ulcer” to “pressure injury” in the ICD-10 and other diagnostic catalogues and classification systems.

121. ADVANCED CARE PLANNING CODES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-70.919, H-85.956 AND H-140.845 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association assess the degree of use of CPT Codes 99497 and 99498 since they were established; and be it further

RESOLVED, That our AMA study the barriers to discussion about advanced care planning by physicians and patients; and be it further

RESOLVED, That our AMA advocate for the expanded use of CPT Codes 99497 and 99498 when sufficient time and effort is spent in face-to-face contact with patients and families and when spread out over multiple clinical visits in order to satisfy the time requirements, due to the complexity of the subject matter.

122. REIMBURSEMENT FOR THE PRE-COLONOSCOPY VISIT
Introduced by American Society for Gastrointestinal Endoscopy, American College of Gastroenterology, American Gastroenterological Association

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-330.950 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association request that the Secretary of Health and Human Services consider allowing Medicare to pay for the pre-colonoscopy consultation to ensure that patients are well chosen, well informed about their choices and well versed in preparation for their colonoscopies.

123. IMPROVING THE PREVENTION OF COLON CANCER BY INSURING THE WAIVER OF THE CO-PAYMENT IN ALL CASES
Introduced by American Society for Gastrointestinal Endoscopy, American College of Gastroenterology, American Gastroenterological Association

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-165.840, H-185.954, H-185.960, H-330.877, H-425.987 and H-425.992

RESOLVED, That our American Medical Association reaffirm Policies H-165.840, H-185.954, H-185.960, H-425.987 and H-425.992; and be it further

RESOLVED, That our AMA support requiring Medicare to waive the coinsurance for colorectal screening tests, including therapeutic intervention(s) required during the procedure.

124. EMERGENCY MEDICAL SERVICES PAYMENT FOR ONSITE TREATMENT AND TRANSPORT TO NON-TRADITIONAL DESTINATIONS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy H-240.978

RESOLVED, That our American Medical Association amend Policy H-240.978, "Medicare's Ambulance Service Regulations," by addition and deletion to read as follows:

> The AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to ~~facilities other than the closest based upon the physician's judgment~~ the most appropriate facility based on the patient's needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction; and be it further

RESOLVED, That our AMA work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS-defined transport locations.

125. MEDICAID SUBSTANCE USE DISORDER COVERAGE
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-290.962 and H-320.945

RESOLVED, That our American Medical Association advocate that the Centers for Medicare and Medicaid Services (CMS) provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders; and be it further

RESOLVED, That our AMA advocate for clear billing and coding processes regarding the medical management and treatment of all substance use disorders; and be it further

RESOLVED, That our AMA recognize the expertise of addiction specialist physicians and the importance of improving access to management and treatment of addiction services with Medicaid payment for all physician specialties; and be it further

RESOLVED, That our AMA reaffirm Policy H-320.945, which opposes abuse of prior authorization.

126. INSURANCE COVERAGE FOR COMPRESSION STOCKINGS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-330.876

RESOLVED, That our American Medical Association support Medicare payment for gradient compression stockings as prescribed by a physician under Medicare benefits coverage.

127. BALANCE BILLING STATE REGULATION
Introduced by Washington

Resolution 127 was considered with resolutions 108, 115 and 118. See Resolution 108.

RESOLVED, That our American Medical Association report on the status of the various current efforts across the country, including the many state legislative efforts, to limit non-Medicare balance billing; and be it further

RESOLVED, That our AMA develop model state legislation to assist its component members in their advocacy efforts against current efforts to regulate balance billing; and be it further

RESOLVED, That the Board of Trustees report back to the House of Delegates at the 2017 Interim Meeting according to AMA Policy D-380.996.

128. PROTECTING PATIENTS' ACCESS TO EMERGENCY SERVICES
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-130.970

RESOLVED, That our American Medical Association work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care.

201. IMPROVING DRUG AFFORDABILITY
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-110.987

RESOLVED, That our American Medical Association support drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; and be it further

RESOLVED, That our AMA support legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and be it further

RESOLVED, That our AMA support the expedited review of generic drug applications and prioritize review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

202. PROTECT INDIVIDUALIZED COMPOUNDING IN PHYSICIANS' OFFICES
Introduced by Louisiana

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-120.930 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association strongly request the US Food and Drug Administration (FDA) withdraw its draft guidance "Insanitary Conditions at Compounding Facilities" and that no further action be taken by the agency until revisions to the USP Chapter <797> on Sterile Compounding, have been finalized; and be it further

RESOLVED, That our AMA work with the US Congress to adopt legislation that would preserve physician office-based compounding as the practice of medicine and codify in law that physicians compounding medications in their offices for immediate or subsequent use in the management of their patients are not compounding facilities under the jurisdiction of the FDA.

203. AMA TO SUPPORT PHARMACEUTICAL PRICING NEGOTIATION IN US
Introduced by Missouri

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-330.954

RESOLVED, That our American Medical Association prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Resolution 204 was moved to Reference Committee A. See Resolution 127.

205. LIMITING MEDICARE PART D ENROLLEE COSTS
Introduced by Washington

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-110.990 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for a Medicare Part D limiting charge for prescription medications; and be it further

RESOLVED, That our AMA advocate for a Medicare Part D annual out-of-pocket limit.

206. MACRA AND THE INDEPENDENT PRACTICE OF MEDICINE

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ALTERNATIVE RESOLUTION 206 ADOPTED
IN LIEU OF RESOLUTIONS 206, 209 AND 222
See Policy H-390.837

RESOLVED, That our AMA, in the interest of patients and physicians, encourage the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care; and be it further

RESOLVED, That our AMA advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program; and be it further

RESOLVED, That our AMA urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.

207. SKY ROCKETING DRUG PRICES
Introduced by Washington

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-110.986, H-110.987, H-110.988, H-110.990, H-110.991 AND H-110.997 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association strongly advocate for policies, regulations and legislation that protect patients from sky rocketing exorbitant prices for previously affordable drugs; and be it further

RESOLVED, That our AMA advocate for an "out of pocket" maximum dollar amount for total drug costs for our patients not to exceed $500 per month.

208. HOUSING PROVISION AND SOCIAL SUPPORT TO IMMEDIATELY ALLEVIATE CHRONIC HOMELESSNESS IN THE UNITED STATES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our AMA amend Policy H-160.903 by addition to read as follows:

H-160.903, Eradicating Homelessness
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance; and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.

209. REDUCE PHYSICIAN PRACTICE ADMINISTRATIVE BURDEN
Introduced by New York

Resolution 209 was considered with Resolutions 206 and 222. See Resolution 206.

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

RESOLVED, That, should full repeal not be achievable, our AMA advocate for legislation and/or regulation to significantly reduce the administrative burdens and penalties associated with compliance with the MIPS and APM programs.

210. VIOLATION OF HIPAA ELECTRONIC TRANSACTION STANDARDS BY INSURER
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-70.944

RESOLVED, That our American Medical Association present information on ICD-10 improper claim denials to the Centers for Medicare and Medicaid Services (CMS) and its Office of E-Health Standards & Services, to determine whether the insurers' failure to properly update their claims processing systems has constituted a violation of the HIPAA Electronic Transaction Standards and should trigger disciplinary or corrective actions to prevent these occurrences in the future.

211. SALE OF HEALTH INSURANCE ACROSS STATE LINES

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ALTERNATIVE RESOLUTION 211 ADOPTED
IN LIEU OF RESOLUTIONS 211 AND 240
See Policy H-180.946

RESOLVED, In examining proposals to sell health insurance across state lines, our AMA supports the following principles:

1. Federal or state legislation allowing the selling of health insurance across state lines, including multi-state compacts, should ensure that patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. These protections include not weakening any state's laws or regulations involving: (a) network adequacy and transparency; (b) fair contracting and claims handling; (c) prompt pay for physicians; (d) regulation of unfair health insurance market products and activities; (e) rating and underwriting rules; (f) grievance and appeals procedures; and (g) fraud; and
2. Patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides.

212. ADVOCACY FOR SEAMLESS INTERFACE BETWEEN PHYSICIAN ELECTRONIC HEALTH RECORDS, PHARMACIES AND PRESCRIPTION DRUG MONITORING PROGRAMS TO BE CREATED AND FINANCED BY THE COMMERCIAL EHR AND DISPENSING PROGRAM PROVIDERS
Introduced by American College of Legal Medicine

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association join the American College of Legal Medicine to advocate federally-mandated interfaces between provider/dispenser electronic health record systems in the clinical, hospital and pharmacy environments and state prescription drug databases and/or prescription drug management plans; and be it further

RESOLVED, That our AMA advocate that the cost of generating these interfaces be borne by the commercial EHR and dispensing program providers; and be it further

RESOLVED, That our AMA advocate that the interface should include automatic query of any opioid prescription, from a provider against the state prescription drug database/prescription drug management plan (PDMP) to determine whether such a patient has received such a medication, or another Schedule II drug from any provider in the preceding ninety (90) days; and be it further

RESOLVED, That our AMA advocate that the prescriber and the patient's EHR-listed dispensing pharmacy should then be notified of the existence of the referenced patient in the relevant PDMP database, the substance of the previous prescription(s) (including the medication name, number dispensed and prescriber's directions for use) in real time and prior to the patient receiving such medication; and be it further

RESOLVED, That our AMA advocate that the electronic record management program at the pharmacy filling the relevant prescription, contemporaneously as it enters the filling of the prescription by the pharmacist, likewise be required to automatically query the state PDMP as a secondary mechanism to prevent inappropriate prescribing, forgery, duplication and/or too great a frequency of use of the involved controlled medication; and be it further

RESOLVED, That our AMA work with ACLM and other concerned societies to urge Congress to timely enact and implement such a statutory scheme supported by a workable and concise regulatory framework, chiefly concentrating on the interfacing of all applicable electronic health record and pharmaceutical dispensing systems with every individual state's PDMP, thereafter designating a timeframe wherein all treating providers and dispensing pharmacists would be required to perform such queries, in concert with the routine ordering of and filling of a controlled substance to be used in the treatment of patients; and be it further

RESOLVED, That our AMA advocate that oversight of the appropriate prescribing of and filling of prescriptions for controlled substances remain with the involved individual federal and state criminal law enforcement agencies, the involved state departments of health, or similar entities and the involved relevant state provider and/or pharmacy licensure authorities; and be it further

RESOLVED, That our AMA advocate that statistics be maintained and reviewed on a periodic basis by state PDMP personnel and relayed to state departments of health or agencies similarly situated so as to identify and possibly treat those patients identified through this screening mechanism as potential drug abusers and/or at risk of addiction.

213. COPYING AND/OR SCANNING COSTS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association seek changes to the federal HIPAA regulations so that charges related to providing patient records defer to state law when charges to be imposed for searching, retrieval and other matters are determined.

214. MEDICAL LIABILITY COVERAGE THROUGH THE FEDERAL TORT CLAIMS ACT
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association seek legislation that would lead to malpractice insurance coverage through the Federal Tort Claims Act for all physicians who participate in Medicare and/or Medicaid and all federal insurance plans.

215. REVISITING EXEMPTIONS FOR REPORTING PEER-REVIEWED JOURNAL ARTICLES AND MEDICAL TEXTBOOKS PER THE SUNSHINE ACT
Introduced by American Medical Group Association

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY D-140.958 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work again, first, with the Centers for Medicare and Medicaid Services (CMS) to administratively expand the Sunshine Act exception (that covers "…educational materials that directly benefit patients or are intended for patient use") to include peer-reviewed journal articles and medical textbooks when provided to physicians; and be it further

RESOLVED, That if no redress is obtained from CMS, that our AMA work again, with the Congress to, once and for all, legislatively expand the exception in ACA section 1128G(e)(10)(B)(iii) to include peer-reviewed journal articles and medical textbooks when provided to physicians.

216. ELECTRONICALLY PRESCRIBE CONTROLLED SUBSTANCES WITHOUT ADDED PROCESSES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate for full electronic prescribing of all prescriptions, without additional cumbersome electronic verification, including Schedule 2-5 controlled substances, eliminating the need for "wet signed" paper prescriptions and faxes for specific classes of prescriptions.

217. INAPPROPRIATE REQUESTS FOR DEA NUMBERS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-100.972 AND H-100.982 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association create a national registry or database where physicians can report inappropriate uses or requests for their DEA numbers; and be it further

RESOLVED, That our AMA educate or seek penalties for those entities requesting or requiring use of DEA numbers outside of the prescribing of controlled substances; and be it further

RESOLVED, That our AMA encourage the federal government to monitor and shut down any electronic means, including websites, that collect and distribute providers' DEA numbers, which would serve to protect the public and minimize the ''hassle factor'' for physicians.

218. LICENSING OF ELECTRONIC HEALTH RECORDS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association develop model legislation for licensing electronic health records with a focus on ensuring system interoperability.

219. INTEGRATION OF DRUG PRICE INFORMATION INTO ELECTRONIC MEDICAL RECORDS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support the incorporation of estimated patient out of pocket drug costs into electronic medical records in order to help reduce patient cost burden; and be it further

RESOLVED, That our AMA collaborate with invested stakeholders, such as physician groups, Electronic Medical Records (EMR) vendors, hospitals, insurers, and governing bodies to integrate estimated out of pocket drug costs into electronic medical records in order to help reduce patient cost burden.

220. ACCOUNTABILITY OF 911 EMERGENCY SERVICES FUNDING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-440.822

RESOLVED, That our American Medical Association encourage federal guidelines and state legislation that protects against reallocation of 911 funding to unrelated services.

221. AMA POLICY ON AMERICAN HEALTH CARE ACT
Introduced by New York

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-165.828, H-165.835, H-165.838, H-165.888, D-165.935, D-165.938 AND D-165.940 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association engage in negotiations with the current leadership of the United States to craft healthcare policy that is in keeping with AMA values.

222. RESPONSE TO BURDENSOME GOVERNMENTAL MANDATE
Introduced by Oklahoma

Resolution 222 was considered with Resolutions 206 and 209. See Resolution 206.

RESOLVED, That our American Medical Association, in the interest of patients and physicians, encourage the Centers for Medicare and Medicaid Services, Congress and the Trump Administration to revise the Merit Based Incentive Payment System to a simplified quality and payment system, with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.

223. TAX DEDUCTIONS FOR DIRECT-TO-CONSUMER ADVERTISING
Introduced by California

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-105.988 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

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

224. MEDICARE PREPAYMENT AND RAC AUDIT REFORM
Introduced by California

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-330.921 AMENDED IN LIEU OF RESOLUTION 224

Policy H-330.921, "Medicare Prepayment and Postpayment Audits," amended by addition to read as follows:

1. AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts:
   (a) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document;
   (b) CMS should discontinue random prepayment audits of E&M services;
   (c) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers;
   (d) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and
   (e) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard.

2. Our AMA advocates that all government recovery programs contain complete physician access to any data mining criteria and programs, that there is same-specialty/same-subspecialty physician review prior to denial of claims, and that any denial of claims be based on medical necessity review as determined by that same-specialty/same-subspecialty physician reviewer, and will explore options for increased reimbursement of physician costs related to government audits, including remedies available through the Equal Access to Justice Act.

3. Our AMA supports the enactment of federal legislation or regulation that requires fairness in the practice of conducting physicians' post-payment audits as contained in paragraph 1 above, and which would include the following:
   (a) The requirement for such audits to be reviewed by a physician board certified within the same specialty prior to any requirement for repayment by the audited physician;
   (b) The requirement for the repayment to be placed in escrow until the appeals process is complete;
   (c) The removal of any incentives that are based upon a percentage of recovery for contracted government auditors;
   (d) The establishment of a mechanism for recovery of a practice's legal fees incurred for unsuccessful audits;
   (e) The full disclosure of contract terms with audit contractors;
   (f) The elimination or improvement of the extrapolation formula;
   (g) The payment for costly documentation requests;
   (h) Imposition of penalties on auditors for inaccurate findings, and
   (i) Incentivizing the auditors to perform more physician education.

4. Our AMA formally request that Medicare employ rules for prepayment and postpayment audits that are at least as protective as the Recovery Audit Contractor (RAC) rules for physicians, and that our AMA continue to advocate for reforms to the audit process, including giving great weight to the treating physician's determination of medical necessity.

5. Our AMA propose to Medicare that there be a mechanism by which prepayment and postpayment audit denials can be resolved via the telephone or other electronic communications.

225. TRUTH IN ADVERTISING
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY H-405.969 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support clarity and truth in advertising by requiring physicians to fully disclose board certification status, medical license restrictions as permitted by law, residency and fellowship status, particularly with vulnerable patients such as those treated in confined settings such as locked mental health institutions and correctional settings and encourage restricting the use of the title "doctor" in closed settings to only medical doctors.

226. DIRECT AMERICAN MEDICAL ASSOCIATION TO ASK CMS AND HHS TO REMOVE PRACTICE EXPENSE AND MALPRACTICE EXPENSE FROM PUBLICLY REPORTED PAYMENTS
Introduced by Ohio

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-406.993

RESOLVED, That our American Medical Association petition the Centers for Medicare & Medicaid Services and the Office of Health & Human Services to remove practice expense and malpractice expense from reimbursements reported to the public.

227. IMPROVING CLINICAL UTILITY OF MEDICAL DOCUMENTATION
Introduced by Ohio

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-478.995

RESOLVED, That our American Medical Association advocate for appropriate, effective and less burdensome documentation requirements in the use of electronic health records.

228. FREE SPEECH APPLIES TO SCIENTIFIC KNOWLEDGE
Introduced by Maryland

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-460.895

RESOLVED, That our American Medical Association advocate that scientific knowledge, data and research will continue to be protected and freely disseminated in accordance with the U.S. First Amendment.

229. MEDICARE'S APPROPRIATE USE CRITERIA PROGRAM
Introduced by American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Neurology, American Association of Neurological Surgeons, American Association of Orthopaedic Surgeons, American Society for Gastrointestinal Endoscopy, American Society of Echocardiography, American Society of Neuroimaging, American Urological Association, Congress of Neurological Surgeons, North American Spine Society, Society for Cardiovascular Angiography and Interventions, American Society of Plastic Surgeons

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-320.940

RESOLVED, That our American Medical Association continue to advocate to delay the effective date of the Medicare AUC Program until the Centers for Medicare & Medicaid Services can adequately address technical and workflow challenges with its implementation and any interaction between the Quality Payment Program and the use of advanced diagnostic imaging appropriate use criteria.

230. CMS REIMBURSEMENT GUIDELINES FOR TEACHING PHYSICIAN SUPERVISION
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association recommend that the Centers for Medicare and Medicaid Services change its policy to allow reimbursement for minor procedures performed by residents as long as the supervising physician is present for the key portions of the minor procedure.

231. NALOXONE PRICE INCREASE
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-95.932

RESOLVED, That our American Medical Association amend existing AMA Policy H-95.932, "Increasing Availability of Naloxone," by addition and deletion as follows:

1. Our AMA supports legislative, ~~and~~ regulatory, and national advocacy efforts ~~that~~ to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.

232. CREATE MACRA OPT-OUT OPTION
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-390.838 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to permit solo practitioners and small practices to opt-out of the Medicare Access and CHIP Reauthorization Act completely in order to protect their financial viability.

233. REGULATION OF PHYSICIAN ASSISTANTS
Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery Association, American College of Mohs Surgery, American Society of Dermatopathology, Society for Investigative Dermatology, Wisconsin

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: RESOLVES 1 AND 2 ADOPTED
PROPOSED THIRD RESOLVE REFERRED FOR DECISION
See Policy H-35.965

RESOLVED, That our American Medical Association advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; and be it further

RESOLVED, That our AMA oppose legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview.

FOLLOWING RESOLVE REFERRED FOR DECISION:

RESOLVED, That our AMA will adopt policy that APRNs are subject to the jurisdiction of state medical licensing and regulatory boards for the regulation and discipline of APRNs in their performance if medical acts, and that our AMA will develop model state legislation in support of states to accomplish this policy.

234. PROTECTIONS FOR PATIENTS WITH GENETIC CONDITIONS
Introduced by American Academy of Neurology, American College of Rheumatology, The Endocrine Society

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-65.965, H-65.969, H-165.856, H-170.963, H-185.972, H-315.983 AND D-185.981 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association actively oppose the Preserving Employee Wellness Programs Act; and be it further

RESOLVED, That our AMA support efforts to preserve nondiscrimination protections established by the Genetic Information Nondiscrimination Act and the Americans with Disabilities Act.

235. TOWARDS ELIMINATING ERISA STATE PREEMPTION OF HEALTH PLAN LIABILITY
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-285.915, H-285.945, D-385.973 AND D-385.984 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association renew active advocacy for Executive and Congressional action to amend the Employee Retirement Income Security Act (ERISA) to eliminate the state preemption clause and provide patients with a less restrictive and/or less burdensome process to seek adequate redress or compensation for damages incurred as a result of coverage decisions made by employer-sponsored health plans; and be it further

RESOLVED, That our AMA reaffirm Policies H-285.945, H-285.915, D-385.984 and D-385.973.

236. RETAIL PRICE OF DRUGS DISPLAYED IN DIRECT-TO-CONSUMER PHARMACEUTICAL ADVERTISING
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-105.988

RESOLVED, That our American Medical Association advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs.

237. PROTECTION OF CLINICIAN-PATIENT PRIVILEGE
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate to the relevant national bodies for the clinician-patient privilege to be regulated according to the privacy protections in the Health Insurance Portability and Accountability Act of 1996 without regard to where care is received.

238. LIMITATION ON REPORTS TO THE NATIONAL PRACTITIONER DATA BANK UNRELATED TO PATIENT CARE
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-355.976

RESOLVED, That our American Medical Association request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial of physicians be (1) contingent upon competency or conduct related to the physicians' provision of or failure to provide healthcare services that adversely affect the health or welfare of a patient, and (2) only based on a professional review action and not for administrative or eligibility reasons; and be it further

RESOLVED, That our AMA advocate that HRSA remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to competence or conduct that adversely affected the health or welfare of a patient.

239. AMA SUPPORT FOR TEXTING AS APPROVED HIPAA COMMUNICATION
Introduced by Tennessee

Resolution 239 was considered with Board of Trustees Report 11, which was adopted in lieu of following resolution. See Board of Trustees Report 11.

RESOLVED, That our American Medical Association collaborate with medical technology companies and the federal government to improve texting platforms so that more commercially available devices comply with HIPAA without having to utilize expensive and complex encryption technology; and be it further

RESOLVED, That our AMA advocate for the relaxation of HIPAA rules regulating the use of commercially available devices to transfer protected health information.

240. MINIMUM FEDERAL STANDARDS FOR INTERSTATE SALE OF HEALTH INSURANCE
Introduced by Texas

Resolution 240 was considered with Resolution 211. See Resolution 211.

RESOLVED, That our American Medical Association advocate for the establishment of minimum federal standards on the interstate sale of health insurance, consistent with existing AMA policy; and be it further

RESOLVED, That our AMA advocate that minimum federal standards should not weaken any states' requirements on network adequacy, tort, financial protections, and other relevant insurance plan regulations.

241. TIMELINESS IN OBTAINING MEDICAL RECORDS FROM OTHER PROVIDERS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY D-190.992 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work in concert with hospitals, hospital associations, and accrediting organizations to achieve a universal understanding of HIPAA rules that allow the transfer of information to members of a patient's treatment team without written authorization.

242. LEGISLATION TO REQUIRE TIMELY ACTION ON PRIOR AUTHORIZATION REQUIREMENTS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-320.948, H-320.952, H-320.958 AND H-320.968 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for the initiation of legislation or regulation requiring utilization review entities to provide detailed explanations for prior authorization or step therapy denials; and be it further

RESOLVED, That our AMA advocate for the initiation of legislation or regulation requiring utilization review entities to make prior authorization or step therapy determinations and to notify providers within 48 hours for non-urgent care. For urgent care, determinations should be made within 24 hours of submission of necessary information; and be it further

RESOLVED, That our AMA advocate for the initiation of legislation or regulation requiring utilization review entities to communicate decisions on appeals within 10 calendar days. In the event that a provider determines the need for an expedited appeal, utilization review entities should communicate decisions on such appeals within 24 hours; and be it further

RESOLVED, That our AMA advocate for the initiation of legislation or regulation requiring that all utilization review entity appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider, and (b) was not involved in the initial adverse determination.

243. SEAMLESS DIGITAL INTERFACE FOR BEST CARE
Introduced by Oregon

Reference committee hearing: see report of Reference Committee B.

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

RESOLVED, That our American Medical Association advocate for the interoperability of electronic medical data platforms for the purpose of improving patient care.

301. MENTAL HEALTH DISCLOSURES ON PHYSICIAN LICENSING APPLICATIONS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
FOURTH RESOLVE REFERRED
See Policy H-295.858

RESOLVED, That our American Medical Association encourage state medical boards to consider physical and mental conditions similarly; and be it further

RESOLVED, That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and be it further

RESOLVED, That our AMA encourage state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

FOLLOWING RESOLVE REFERRED:

RESOLVED, That our AMA amend Policy H-275.970, "Licensure Confidentiality," by addition and deletion to read as follows:

H-275.970, Licensure Confidentiality
The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician's practice of medicine or presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~

302. COMPREHENSIVE REVIEW OF CME PROCESS
Introduced by Missouri

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-300.980

RESOLVED, That our American Medical Association, in collaboration with the Accreditation Council for Continuing Medical Education, do a comprehensive review of the continuing medical education (CME) process on a national level, with the goal of decreasing costs and simplifying the process of providing CME.

303. ADDRESSING MEDICAL STUDENT MENTAL HEALTH THROUGH DATA COLLECTION AND SCREENING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-295.858

RESOLVED, That our American Medical Association encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and be it further

RESOLVED, That our AMA encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and be it further

RESOLVED, That our AMA work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

304. SUPPORT OF EQUAL STANDARDS FOR FOREIGN MEDICAL SCHOOLS SEEKING TITLE IV FUNDING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-255.988

RESOLVED, That our American Medical Association support the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

305. REDUCTION OF CAREGIVER BURNOUT
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-210.980

RESOLVED, That our American Medical Association encourage partner organizations to develop resources to better prepare and support lay caregivers; and be it further

RESOLVED, That our AMA identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.

306. U.S. INTERNATIONAL MEDICAL GRADUATES IN PHYSICIAN WORKFORCE
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-310.977

RESOLVED, That the American Medical Association encourage the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program (NRMP) and are therefore unable to get a residency or practice medicine.

307. FORMAL BUSINESS AND PRACTICE MANAGEMENT TRAINING DURING MEDICAL EDUCATION
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: POLICIES H-295.864, H-295.924, H-405.990 AND D-295.316 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage the Liaison Committee for Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), Association of American Medical Colleges (AAMC) and other entities responsible for medical education to advocate for and support the creation of a more standardized process and approach for training and education in business and practice management skills for medical practitioners across the continuum of medical school, residency, fellowship and independent practice; and be it further

RESOLVED, That our AMA encourage LCME, ACGME, AAMC and other entities responsible for the education of future physicians, to provide educational resources and programs on business administration and practice management in their medical education curriculum.

308. IMPACT OF IMMIGRATION BARRIERS ON THE NATION'S HEALTH

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ALTERNATIVE RESOLUTION 308 ADOPTED IN LIEU OF RESOLUTIONS 308, 311, 312, 317, 321, 325 AND 326
See Policy D-255.980

RESOLVED, That our American Medical Association (AMA) recognize the valuable contributions and affirm our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine; and be it further

RESOLVED, That our AMA oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion; and be it further

RESOLVED, That our AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion; and be it further

RESOLVED, That our AMA advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care; and be it further

RESOLVED, That our AMA advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice; and be it further

RESOLVED, That our AMA work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.; and be it further

RESOLVED, That our AMA update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.

309. FUTURE OF THE USMLE: EXAMINING MULTI-STEP STRUCTURE AND SCORE USAGE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-275.953 and H-275.962

RESOLVED, That our American Medical Association work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies; and be it further

RESOLVED, That our AMA work with the appropriate stakeholders to study alternate means of scoring USMLE exams in order to avoid the inappropriate use of USMLE scores for screening residency applicants.

310. BREAST PUMP ACCOMMODATIONS DURING MEDICAL LICENSING EXAMS
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: POLICY H-295.861 AMENDED IN LIEU OF RESOLUTION 310

Policy H-295.861 amended by addition and deletion to read as follows:

> Our AMA 1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give ~~lactating mothers~~ breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and 2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump.

311. SUPPORT OF INTERNATIONAL MEDICAL STUDENTS AND GRADUATES
Introduced by Wisconsin

Resolution 311 was considered with Resolutions 308, 312, 317, 321, 325 and 326. See Resolution 308.

RESOLVED, That our American Medical Association recognize the unique contributions and affirm our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine; and be it further

RESOLVED, That our AMA oppose changes to immigration policies for international and foreign-born medical graduates and students that use country of origin to restrict visa procurement and ability to travel outside of the U.S. and return with a visa.

312. SUPPORTING INTERNATIONAL MEDICAL GRADUATES AND STUDENTS
Introduced by New York

Resolution 312 was considered with Resolutions 308, 311, 317, 321, 325 and 326. See Resolution 308.

RESOLVED, That our American Medical Association oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion; and be it further

RESOLVED, That our AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

313. STUDY OF DECLINING NATIVE AMERICAN MEDICAL STUDENT ENROLLMENT
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy D-200.985

RESOLVED, That our American Medical Association partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

314. EDUCATING A DIVERSE PHYSICIAN WORKFORCE
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-200.985

RESOLVED, That our American Medical Association develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population; and be it further

RESOLVED, That our AMA provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity; and

RESOLVED, That our AMA create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers; and be it further

RESOLVED, That our AMA create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs; and be it further

RESOLVED, That our AMA recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education; and be it further

RESOLVED, That our AMA advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Resident Application Service (ERAS) applications through the National Residency Matching Program (NRMP); and be it further

RESOLVED, That our AMA continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

315. INCLUSION OF DEVELOPMENTAL DISABILITIES CURRICULUM IN UNDERGRADUATE, GRADUATE AND CONTINUING MEDICAL EDUCATION OF PHYSICIANS
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-90.968 and H-90.969

RESOLVED, That our American Medical Association reaffirm AMA Policies H-90.968, "Medical Care of Persons with Developmental Disabilities," and H-90.969, "Early Intervention for Individuals with Developmental Delay"; and be it further

RESOLVED, That our AMA recognize the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community; and be it further

RESOLVED, That our AMA support efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities; and be it further

RESOLVED, That our AMA encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities; and be it further

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities; and be it further

RESOLVED, That our AMA encourage the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.

316. ACTION STEPS REGARDING MAINTENANCE OF CERTIFICATION
Introduced by Florida, Pennsylvania, Georgia, California, New York, Arizona, Texas, American College of Radiation Oncology, American Society of Interventional Pain Physicians

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
TWO ADDITIONAL RESOLVES REFERRED
See Policies H-300.958 AND D-275.954

RESOLVED, That our American Medical Association affirm that lifelong learning is a fundamental obligation of our profession; and be it further

RESOLVED, That our AMA recognize that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) appropriate to that physician's medical practice as determined by the relevant specialty society; and be it further

RESOLVED, That Policy D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification," be reaffirmed; and be it further

FOLLOWING RESOLVES REFERRED:

RESOLVED, That our AMA join with state medical associations and specialty societies in directly lobbying state medical licensing boards, hospital associations, and health care insurers to adopt policy supporting the use of satisfactory demonstration of lifelong learning with high quality CME as specified by a physician's specialty society for credentialing and bar these entities from using the ABMS sponsored MOC process using lifelong interval high stakes testing for credentialing; and be it further

RESOLVED, That our AMA partner with state medical associations and specialty societies to undertake a study with the goal of establishing a program that will certify physicians as satisfying the requirements for continuation of their specialty certification by successful demonstration of lifelong learning utilizing high quality CME appropriate for that physician's medical practice as determined by their specialty society with a target start date of 2020 or before, with report back biannually to the HOD and AMA members.

317. IMMIGRATION
Introduced by Michigan

Resolution 317 was considered with Resolutions 308, 311, 312, 321, 325 and 326. See Resolution 308.

RESOLVED, That our American Medical Association lobby the US Congress and other appropriate US government officials to exempt physicians from any current or future ban or suspension impacting immigration or the issuance of a J1 Visa or H1-B Visa.

318. OPPOSE DIRECT TO CONSUMER ADVERTISING OF THE ABMS MOC PRODUCT
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists; and be it further

RESOLVED, That our AMA amend existing AMA Policy D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification" by addition as follows:

> 36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards' websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes.

319. PUBLIC ACCESS TO INITIAL BOARD CERTIFICATION STATUS OF TIME-LIMITED ABMS DIPLOMATES
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-275.924

RESOLVED, That our American Medical Association amend the AMA Principles of Maintenance of Certification (MOC), AMA Policy H-275.924, "Maintenance of Certification," by addition as follows:

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards' websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards' websites or physician certification databases even if the diplomate chooses not to participate in MOC.

320. CULTURAL COMPETENCE IN STANDARDIZED PATIENT PROGRAMS WITHIN MEDICAL EDUCATION
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-295.897

RESOLVED, That our American Medical Association amend existing AMA Policy H-295.897, "Enhancing the Cultural Competence of Physicians" by addition as follows:

7. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.

321. CONTINUED SUPPORT OF H-1B VISA PROGRAMS FOR INTERNATIONAL MEDICAL GRADUATES
Introduced by Minnesota

Resolution 321 was considered with Resolutions 308, 311, 312, 317, 325 and 326. See Resolution 308.

RESOLVED, That our American Medical Association urge the Trump Administration to immediately reinstate premium processing of H-1B visas for physicians to prevent any negative impact on patient care in underserved communities.

322. ENDING MAINTENANCE OF CERTIFICATION EXAMINATIONS
Introduced by New Hampshire

Reference committee hearing: see report of Reference Committee C.

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

RESOLVED, That our American Medical Association oppose the requirement of Maintenance of Certification (MOC) as currently constituted in privileging and credentialing providers by health systems, hospitals, and payers; and be it further

RESOLVED, That our AMA call on the American Board of Medical Specialties to pursue ongoing meaningful continuing medical education as a pathway to MOC without the requirement for re-examination; and be it further

RESOLVED, That our AMA reaffirm Policies H-275.924 and D-275.954, and report back at the 2017 Interim Meeting with an update on progress made to toward these policies.

323. EXCEPTIONS TO MEDICARE GME CAP-SETTING DEADLINES FOR RESIDENCY PROGRAMS IN MEDICALLY UNDERSERVED/ECONOMICALLY DEPRESSED AREAS
Introduced by Texas

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy D-305.967

RESOLVED, That our American Medical Association advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas.

324. IMPROVE HRSA PROJECTIONS OF THE PHYSICIAN WORKFORCE
Introduced by American College of Rheumatology

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-200.955

RESOLVED, That our American Medical Association encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

325. ENSURE AN EFFECTIVE H-1B VISA PROGRAM TO PROTECT PATIENT ACCESS TO CARE
Introduced by American College of Rheumatology

Resolution 325 was considered with Resolutions 308, 311, 312, 317, 321 and 326. See Resolution 308.

RESOLVED, That our American Medical Association proactively work with appropriate officials to secure an exemption of medical professionals from the suspension of and any future modifications to the H-1B visa program, in order to allow for efficient entry of international physicians into the United States.

326. SUPPORTING INTERNATIONAL MEDICAL GRADUATES AND STUDENTS
Introduced by Young Physicians Section

Resolution 326 was considered with Resolutions 308, 311, 312, 317, 321 and 325. See Resolution 308.

RESOLVED, That the American Medical Association oppose laws and regulations that would broadly deny entry or re-entry to the United States by persons based on their country of origin and/or religion who currently have legal visas, including permanent resident status (green card) and student visas; and be it further

RESOLVED, That the AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

401. USE OF PHRASE "GUN VIOLENCE MITIGATION" IN LIEU OF "GUN CONTROL"
Introduced by Illinois

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY H-145.991 RETITLED AND POLICY H-145.999 AMENDED IN LIEU OF RESOLUTION 401

Policy H-145.991 amended with title change as follows:

~~Gun Control~~ Waiting Periods for Firearm Purchases

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Policy H-145.999 amended by deletion to read as follows:

Gun Regulation

Our AMA supports stricter enforcement of present federal and state gun ~~control~~ legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

402. PERSON-FIRST LANGUAGE FOR OBESITY
Introduced by Obesity Medicine Association, Minority Affairs Section, Colorado, American Society for Metabolic and Bariatric Surgery, The Endocrine Society

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS TITLE CHANGED POLICY H-440.902 AMENDED
See Policies H-440.821 and H-440.902

RESOLVED, That our American Medical Association encourage the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; and be it further

RESOLVED, That our AMA encourage the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and be it further

RESOLVED, That our AMA educate health care providers on the importance of patient-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully; and be it further

RESOLVED, That Policy H-440.902, "Obesity as a Major Health Concern," be amended by addition and deletion to read as follows:

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of ~~obese~~ patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity ~~overweight and obese patients~~.

403. TOBACCO HARM REDUCTION: A COMPREHENSIVE NICOTINE POLICY TO REDUCE DEATH AND DISEASE CAUSED BY SMOKING
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate for tobacco harm reduction approaches to be added to existing tobacco treatment and control efforts; and be it further

RESOLVED, That our AMA educate physicians and patients on the myriad health effects of different nicotine products and emphasize the critical role of smoke and combustion in causing disease; and be it further

RESOLVED, That our AMA encourage physicians to adopt patient-specific, individualized approaches to smoking cessation, particularly for patients with disease secondary to smoking and for patients who have otherwise failed traditional methods for smoking cessation; and be it further

RESOLVED, That our AMA continue its focus on research to identify and expand options that may assist patients to transition away from smoking, including nicotine replacement therapies and noncombustible nicotine products (including e-cigarettes); and be it further

RESOLVED, That the AMA reaffirm its position on strong enforcement of US Food and Drug Administration and other agency regulations for the prevention of use of all electronic nicotine delivery systems and tobacco products by anyone under the legal minimum purchase age. This shall include marketing to children, direct use or purchasing by children and indirect diversion to children. Further, that our AMA reaffirm physician education of patients to limit these products for children in any and all capacity.

404. SUPPORT FOR STANDARDIZED DIAGNOSIS AND TREATMENT OF HEPATITIS C VIRUS IN THE POPULATION OF INCARCERATED PERSONS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-430.985

RESOLVED, That our American Medical Association support the implementation of routine screening for Hepatitis C virus (HCV) in prisons; and be it further

RESOLVED, That our AMA advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and be it further

RESOLVED, That our AMA support negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payers, and drug companies to maximize access to these disease-altering medications.

405. INCREASING OUTDOOR ACTIVITY TO PREVENT MYOPIA ONSET AND PROGRESSION IN SCHOOL CHILDREN

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ALTERNATIVE RESOLUTION 405 ADOPTED IN LIEU OF RESOLUTION 405
See Policy H-60.913

RESOLVED, That our American Medical Association support efforts to increase outdoor time and promote other activities that have been demonstrated to reduce the progression of myopia in children.

406. HEALTHFUL HOSPITAL FOODS
Introduced by District of Columbia

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-150.949

RESOLVED, That our American Medical Association hereby call on US hospitals to improve the health of patients, staff, and visitors by (1) providing a variety of healthful food, including plant-based meals and meals that are low in fat, sodium, and added sugars; (2) eliminating processed meats from menus; and (3) providing and promoting healthful beverages.

407. SNAP REFORM TO IMPROVE HEALTH AND COMBAT FOOD DESERTS
Introduced by District of Columbia

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-150.937

RESOLVED, That our American Medical Association request that the federal government support Supplemental Nutrition Assistance Program (SNAP) initiatives to (1) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (2) harmonize SNAP food offerings with those of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

408. INCREASED OVERSIGHT OF SUICIDE PREVENTION TRAINING FOR CORRECTIONAL FACILITY STAFF
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-430.984

RESOLVED, That our American Medical Association strongly encourage all state and local adult and juvenile correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care standards for accreditation; and be it further

RESOLVED, That our AMA strongly encourage all state and local adult and juvenile correctional facility officers to undergo suicide prevention training annually.

409. PEDIATRIC/ADOLESCENT INFORMED CONSENT CONCUSSION DISCUSSION
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association support federal legislation that includes informed consent prior to participation in intramural and interscholastic athletics and that this consent discuss the risk of short and long term impact of mild traumatic brain injuries.

410. IMPROVING ACCESS TO DIRECT ACTING ANTIVIRALS FOR HEPATITIS C-INFECTED INDIVIDUALS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-440.845

RESOLVED, That our American Medical Association amend current Policy H-440.845 by addition to read as follows:

H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment
Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support programs aimed at training providers in the treatment and management of patients infected with HCV; ~~(4)~~ (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between, the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; ~~and (5)~~ (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; and (7) encourage equitable reimbursement for those providing treatment.

411. VACCINE SAFETY

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ALTERNATIVE RESOLUTION 411 ADOPTED
IN LIEU OF RESOLUTIONS 411 AND 420
See Policies H-440.830 and H-440.875

RESOLVED; That our American Medical Association (1) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (2) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (3) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines; and be it further

RESOLVED, That our AMA reaffirm Policies H-440.830 and H-440.875.

412. ENVIRONMENTAL ASSESSMENT FOR CHILDREN WITH ELEVATED BLOOD LEAD LEVELS

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ALTERNATIVE RESOLUTION 412 ADOPTED IN LIEU OF RESOLUTION 412
See Policy H-60.924

RESOLVED, That our American Medical Association supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.

413. OCULAR BURNS FROM LIQUID LAUNDRY PACKETS
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-60.967

RESOLVED, That our American Medical Association encourage the Consumer Product Safety Commission in conjunction with the American Association of Poison Control Centers to study the impact of "F3159-15 - Consumer Safety Specification for Liquid Laundry Packets" to ensure that the voluntary ASTM standard adequately protects children from injury, including eye injury.

414. SUPPORTING TAXES ON SUGAR-SWEETENED BEVERAGES
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-150.933

RESOLVED, That our American Medical Association will (1) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages, with the investment of the resulting revenue in public health programs to combat obesity and (2) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages as requested.

415. FOOD BANK AND PANTRY DISTRIBUTION OF NUTRIENT-DENSE FOODS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICY H-150.930 AMENDED
IN LIEU OF RESOLUTION 415
See Policy H-150.930

Policy H-150.930, "National Nutritional Guidelines for Food Banks and Pantries," amended by addition and deletion to read as follows:

Our AMA (1) supports ~~of~~ the use of existing national nutritional guidelines for food banks and food pantries and (2) will promote sustainable sourcing of healthier food options and the dissemination of user-friendly resources and education on healthier eating for food banks and food pantries.

416. POLICY AND ECONOMIC SUPPORT FOR EARLY CHILD CARE
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED (AFTER RESOLVE 1 AMENDED)

RESOLVED, That our American Medical Association advocate for improved social and economic support for family leave to care for newborns, infants and young children; and be it further

RESOLVED, That our AMA advocate for federal tax incentives to support early child care and unpaid child care by extended family members.

417. MANDATORY PUBLIC HEALTH REPORTING OF LAW ENFORCEMENT-RELATED INJURIES AND DEATHS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Minority Affairs Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention and state departments of health to collect data on serious law-enforcement-related injuries and deaths and make law-enforcement-related deaths a notifiable condition.

418. DUE PROCESS FOR CDC-IMPOSED QUARANTINES

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ALTERNATIVE RESOLUTION 418 ADOPTED
IN LIEU OF RESOLUTION 418
See Policies H-440.835 and D-440.928 and Opinion E-8.4

RESOLVED, That our American Medical Association seek changes to federal quarantine law to ensure the availability of an expedited judicial review of all CDC-imposed quarantines.

RESOLVED, That Policy H-440.835 and Opinion E-8.4 be reaffirmed.

419. IMPROVING PHYSICIANS' ABILITY TO DISCUSS FIREARM SAFETY
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-145.976

RESOLVED, That our American Medical Association work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

420. EVIDENCE-BASED VACCINATION RECOMMENDATIONS
Introduced by Oregon

Resolution 420 was considered with Resolution 411. See Resolution 411.

RESOLVED, That our American Medical Association support the rigorous scientific process of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices and encourage education of parents and patients on the safety, risks, and benefits of vaccination; and be it further

RESOLVED, That our AMA support both national and state scientifically-based policies that promote the safety of vaccinations and effectively serve to increase the number of individuals vaccinated against communicable diseases.

501. AIRPLANE EMISSIONS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association urge the President and the Environmental Protection Agency to expeditiously publish regulations, including binding limits on carbon dioxide emissions and other hazardous byproducts, that will stimulate development of clean aviation technology.

502. ACCESS TO COSMETIC PRODUCT INGREDIENTS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICY H-440.855 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage the US Food and Drug Administration to mandate that all manufacturers of cosmetics, skincare products, nail polish, and sunscreens make their full ingredient lists available on the package and online to consumers; and be it further

RESOLVED, That our AMA prepare a report to increase awareness of acrylate allergy, update potential sources of occupational and non-occupational exposure, and provide an update as to the best ways and barrier methods to avoid acrylate exposure by susceptible individuals, with a report back to the AMA HOD at the 2017 Interim Meeting.

503. WOMEN AND MENTAL HEALTH
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-345.981, H-345.984, H-420.953 and D-345.997

RESOLVED, That Policy D-345.997 be amended by addition to read as follows:

D-345.997, Access to Mental Health Services
Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness, including barriers that disproportionately affect women and at-risk populations; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process.

RESOLVED, That our AMA recognize the impact of violence and social determinants on women's mental health; and be it further

RESOLVED, That Policy H-345.981 be reaffirmed; and be it further

RESOLVED, That AMA Policy H-420.953, "Improving Mental Health Services for Pregnant and Postpartum Mothers," be amended by addition to read as follows:

H-420.953, Improving Mental Health Services for Pregnant and Postpartum Mothers
Our AMA: 1. supports improvements in current mental health services for women during pregnancy and postpartum; 2. supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; 3. supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and 4. will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety, psychosis and substance use disorder through research, public awareness, and support programs.

504. RESEARCH INTO PRETERM BIRTH AND RELATED CARDIOVASCULAR (CV) AND CEREBROVASCULAR RISKS (CVD) IN WOMEN
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-420.992

RESOLVED, That our AMA advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant women.

505. RECOGNITION OF SEPSIS IN THE COMMUNITY
Introduced by Women Physicians Section

Resolution 505 was considered with Resolution 522. See Resolution 522.

RESOLVED, That our American Medical Association encourage educational and public awareness programs to assure that physicians actively educate their patients and/or caregivers on the signs and symptoms of sepsis; and be it further

RESOLVED, That our AMA encourage increased enrollment in clinical studies with all appropriate sepsis and septic shock patients, to better identify predictors of short and long-term adverse outcomes, and to advance the treatment of sepsis and sepsis-related complications.

506. EXPANDING ACCESS TO BUPRENORPHINE FOR THE TREATMENT OF OPIOID USE DISORDER
Introduced by Medical Student Section, American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: RESOLVE 1 ADOPTED AS FOLLOWS
PROPOSED ADDITIONAL RESOLVE REFERRED FOR DECISION
See Policy D-95.972

RESOLVED, That our American Medical Association's Opioid Task Force publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of opioid use disorder.

FOLLOWING PROPOSED RESOLVE REFERRED FOR DECISION:

RESOLVED, That our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

507. EDUCATING PHYSICIANS AND YOUNG ADULTS ON SYNTHETIC DRUGS
Introduced by Medical Student Section

Resolution 507 was considered with Council on Science and Public Health Report 2, which was adopted in lieu of Resolution 507. See Council on Science and Public Health Report 2.

RESOLVED, That our American Medical Association amend existing AMA Policy H-95.940 by addition to read as follows:

H-95.940, Addressing Emerging Trends in Illicit Drug Use
Our AMA: (1) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, and poison control centers to assess and monitor energy trends in illicit and legal synthetic drug use, and to develop and disseminate fact sheets and other educational materials; (2) encourages the development of continuing medical education on emerging trends in illicit and legal synthetic drug use; and (3) supports efforts by the federal government to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.

508. SUPPORT FOR SERVICE ANIMALS, EMOTIONAL SUPPORT ANIMALS, ANIMALS IN HEALTHCARE, AND MEDICAL BENEFITS OF PET OWNERSHIP
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association (1) recognize the potential medical benefits of animal-assisted therapy and animals as companions; and (2) encourage research into the use and implementation of service animals, emotional support animals and animal-assisted therapy as both a therapeutic and management technique of disorders and handicaps when expert opinion and the scientific literature show a potential benefit.

509. EXPLORING APPLICATIONS OF WEARABLE TECHNOLOGY IN CLINICAL MEDICINE AND MEDICAL RESEARCH
Introduced by Medical Student Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-480.943 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study the safety, efficacy, and potential uses of wearable devices within clinical medicine and clinical research.

510. BAN ON THE USE OF PARAQUAT
Introduced by New York

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association seek appropriate legislation to permanently ban the use of Paraquat in all forms in the United States.

511. FUTURE OF PAIN CARE
Introduced by American Academy of Pain Medicine

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy D-160.922

RESOLVED, That our American Medical Association convene a task force from organized medicine to discuss medicine's response to the public health crisis of undertreated and mistreated pain; and be it further

RESOLVED, That this task force explore and make recommendations for augmenting medical education designed to educate healthcare providers on how to help patients suffering from pain with evidence-based treatment options; and be it further

RESOLVED, That this task force discuss strategies that may prevent or mitigate acute pain, educate physicians about these strategies, and suggest research to study if these strategies prevent the development of chronic pain; and be it further

RESOLVED, That this task force involve many primary care, medical and surgical specialties that are involved in providing pain care.

512. ADVERTISING RESTRICTIONS AND LIMITED USE OF DIETARY SUPPLEMENTS
Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-150.954 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study the need for U.S. Food and Drug Administration regulation of dietary supplements.

513. PILOT IMPLEMENTATION OF SUPERVISED INJECTION FACILITIES

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ALTERNATIVE RESOLUTION 513 ADOPTED
IN LIEU OF RESOLUTIONS 513 AND 524
See Policy H-95.925

RESOLVED, That our American Medical Association support the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.

514. RETINOBLASTOMA DUE TO PRE-NATAL RESIDENTIAL PESTICIDE EXPOSURE
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICY H-135.926 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the potential risks of using pesticides at home for pregnant women, including unilateral retinoblastoma; and

RESOLVED, That our AMA encourage physicians to discuss with patients the potential risks of using pesticides at home for pregnant women, including unilateral retinoblastoma.

515. SAFE USE, STORAGE AND DISPOSAL OF LEFTOVER OPIOIDS AND OTHER CONTROLLED SUBSTANCES
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-95.971

RESOLVED, That our American Medical Association and its Opioid Task Force continue to adapt current educational materials to distribute to prescribers and patients, emphasizing the importance of safe storage and disposal of opioids, and encouraging prescribers and patients to investigate and advocate for more local drug take back programs; and

RESOLVED, That our AMA and its Opioid Task Force encourage all prescribers to work with local organizations and pharmacists to develop and disseminate the most up-to-date information on local Take Back resources; and be it further

RESOLVED, The our AMA and its Opioid Task Force continue to educate all prescribers on the importance of optimal use of opioids, including appropriately limiting the quantities of opioid prescriptions and advocating for e-prescription capabilities for controlled substances.

516. IN-FLIGHT EMERGENCIES
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: POLICIES H-45.978 AND H-45.979 REAFFIRMED
IN LIEU OF RESOLVES 1, 2 AND 4
RESOLVES 3 AND 5 REFERRED FOR REPORT AT 2017 INTERIM MEETING

RESOLVED, That our American Medical Association support and advocate for a requirement that all U.S. based commercial carriers consult with the Air Transport Medicine Committee Aerospace Medical Association every six months to determine the minimal medical equipment that should be available on domestic and international commercial flights and provide easy access to that information to passengers in order to aid in responding to likely emergencies such as adding naloxone to target potential opioid overdoses and a glucometer given the increase prevalence of diabetes; and be it further

RESOLVED, That our AMA support and advocate for a requirement that medical supplies, equipment, and medications available for an inflight medical emergency are standardized based upon the size and mission of the aircraft across all domestic and international commercial US based airlines with careful consideration of flight crew training requirements; and be it further

RESOLVED, That our AMA support and advocate for a requirement that fight crews will no longer be required to verify a medical professional's credentials before allowing that person to assist with an inflight medical emergency; and be it further

RESOLVED, That our AMA support and advocate for a requirement that US based commercial carriers develop an online process for health providers to become credentialed in advance of a flight in order to respond to an inflight emergency; and be it further

RESOLVED, That our AMA offer medical trainees and physicians medical education courses to prepare for addressing in-flight emergencies during its meetings and/or by strongly encouraging its affiliated state and local branches to offer similar education courses.

517. CHOLINE SUPPLEMENTATION IN PRENATAL VITAMINS
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-420.951

RESOLVED, That our American Medical Association support evidence-based amounts of choline in all prenatal vitamins.

518. RECOGNITION OF INFERTILITY AS A DISEASE
Introduced by American Society for Reproductive Medicine, Endocrine Society, American Congress of Obstetricians and Gynecologists, American Urological Association, American Association of Clinical Endocrinologists

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-165.856 and H-420.952

RESOLVED, That our American Medical Association support the World Health Organization's designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention; and be it further

RESOLVED, That our AMA reaffirm Policy H-165.856.

519. LIQUID MEDICATION DOSING
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY D-120.939 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek rules from the US Food and Drug Administration requiring that all orally administered liquid over-the-counter medications list dosing only in metric measurements and that appropriate dosing syringes be provided with all orally administered liquid medications.

520. COMBINATION CLOTRIMAZOLE/BETAMETHASONE DIPROPRIONATE CREAM WARNING
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association work with the US Food and Drug Administration to review the safety and indications of the combination clotrimazole/ betamethasone diproprionate cream and lotion.

521. RETAIL PRESCRIPTION BOTTLE LABEL PRIVACY
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association petition the American Pharmacist Association, the US Food and Drug Administration and other relevant agencies, to recommend that labels used for retail prescription bottles be affixed in a manner that allows easy removal or destruction to protect patient privacy.

522. IMPROVED TREATMENT OF SEPSIS
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 505
TITLE CHANGED
See Policy H-160.898

RESOLVED, That our American Medical Association support innovations and public awareness campaigns that facilitate the early recognition and treatment of sepsis in pediatric and adult populations; and be it further

RESOLVED, That our AMA believes that medical screening, diagnosis and treatment protocols for sepsis should not be mandated by governmental entities in the absence of substantial scientific consensus.

523. AMA SUPPORT FOR EVIDENCE-BASED ENVIRONMENTAL STATUTES AND REGULATIONS
Introduced by Arizona

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy H-135.934

RESOLVED, That our American Medical Association strongly support evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and be it further

RESOLVED, That our AMA advocate that environmental health regulations should only be modified or rescinded with scientific justification.

524. SUPERVISED INJECTION FACILITIES AS HARM REDUCTION TO ADDRESS OPIOID CRISIS
Introduced by Medical Student Section

Resolution 524 was considered with Resolution 513. See Resolution 513.

RESOLVED, That our American Medical Association work with state and local health departments to achieve the legalization and implementation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services.

525. PROVIDING FOR PRESCRIPTION DRUG DONATION
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate for new federal legislation that would allow nursing homes to recycle prescription drugs that are unused, sealed, and dated; and be it further

RESOLVED, That our AMA advocate for new federal legislation that would allow physician offices and clinics to donate prescription drugs that are unused, sealed, and dated to patients in need who are uninsured or underinsured; and be it further

RESOLVED, That our AMA advocate for new federal legislation that would allow cancer programs and clinics to accept and recycle cancer-specific drugs to patients in need who are uninsured or underinsured.

526. FUNDING FOR BASIC AND TRANSLATIONAL PAIN RESEARCH
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-160.981

RESOLVED, That our AMA advocate for increased funding for basic and translational pain research.

601. REINSTATE THE AMA COMMISSION TO ELIMINATE HEALTH CARE DISPARITIES
Introduced by New York

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association reinstate the Commission to Eliminate Health Care Disparities, including goals and objectives that are Specific, Measurable, Agreed Upon, Realistic and Time Related (SMART) metrics.

602. STUDYING HEALTHCARE INSTITUTIONS THAT PROVIDE CHILD CARE SERVICES
Introduced by American Medical Women's Association

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-215.987

RESOLVED, That our American Medical Association (AMA) work with relevant entities to study healthcare institutions to determine whether they provide childcare services. Survey elements should include the size of the institutions in terms of the number of physicians, physicians-in-training, and medical students, how these services are organized, and the various funding mechanisms used for these; and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2018 Annual Meeting the results of its study on models used to provide childcare services, how these services are organized, and the various funding mechanisms.

603. SEXUAL ORIENTATION AND GENDER IDENTITY DEMOGRAPHIC COLLECTION BY THE AMA
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy G-635.125

RESOLVED, That our American Medical Association develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand the demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner.

604. HIGH COST TO AUTHORS FOR OPEN SOURCE PEER REVIEWED PUBLICATIONS
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association investigate the high dollar costs open source publication rules currently present to the dissemination of research, especially by less well-funded and/or smaller entities; and be it further

RESOLVED, That our AMA make recommendations to correct the imbalance of knowledge suppression based solely on financial considerations.

605. PRONUNCIATION OF PHARMACEUTICAL NAMES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association adopt policy that its AMA-sponsored medical journals develop means to convey the proper pronunciation of all new pharmaceutical names.

606. ADD PATIENTS TO THE AMA MISSION STATEMENT
Introduced by Tennessee

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association modify its mission statement to read "The American Medical Association promotes the art and science of medicine, the betterment of public health, and the improvement and accessibility of health care to our patients."

607. AMA TO PROTECT HUMAN HEALTH FROM THE EFFECTS OF CLIMATE CHANGE BY ENDING ITS INVESTMENTS IN FOSSIL FUEL COMPANIES (DIVESTMENT)
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

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

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

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

608. IMPROVING MEDICAL STUDENT, RESIDENT/FELLOW AND ACADEMIC PHYSICIAN ENGAGEMENT IN ORGANIZED MEDICINE AND LEGISLATIVE ADVOCACY
Introduced by Academic Physicians Section, Medical Student Section, Resident and Fellow Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy G-615.103

RESOLVED, That our American Medical Association study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; and be it further

RESOLVED, That our AMA study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and be it further

RESOLVED, That our AMA identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.

609. MODEL HOSPITAL MEDICAL STAFF BYLAWS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association:

1. Develop model hospital medical staff bylaws that incorporate currently believed to be best practices, meet the requirements of the Medicare Conditions of Participation, hospital accreditation organizations with deeming authority, and state laws and regulations, including annotations to show the source of all legal, regulatory, and accreditation requirements; and

2. Post this resource on the AMA website, continuously updated and available on demand to medical staffs, medical staff offices, and medical society staff, and widely distributed as an adjunct to the next edition of the *AMA Physician's Guide to Medical Staff Bylaws*; and be it further

RESOLVED, That our AMA ask the legal counsels of State Medical Societies to outline state specific restrictions of medical staff self-governance so that these may be posted on the AMA-OMSS website for use by all AMA members.

701. THIRD PARTY PAYERS MANDATING DOCTOR AND PATIENT TRANSFERS OF PRESCRIPTIONS
Introduced by Virginia

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-120.927

RESOLVED, That our American Medical Association advocate that insurers or other third party payers must provide 60 days advance notice of changes in retail pharmacy networks to both patients and all physicians treating these patients; and be it further

RESOLVED, That our AMA advocate that insurers or other third party payers making changes to their pharmacy network must allow patients to designate a new pharmacy of choice within the network; and be it further

RESOLVED, That our AMA advocate that when an insurance company or other third party payer mandates prescription transfers due to a change in their retail pharmacy network, that the payer and pharmacies within network have mechanisms in place to seamlessly transfer the prescription, as initially prescribed with regard to refills, substitutions, and other pertinent prescription details, to the patient's pharmacy of choice without the need for the patient/physician to initiate such transfer, as well as safety mechanisms to ensure that the formulation which has been established and tolerated is available to the patient without a lapse in dispensing.

702. CREDENTIALS/SPECIALTY ADDED TO CLINICAL NOTE SIGNATURES
Introduced by Louisiana

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association work collaboratively with appropriate national and state hospital associations and other appropriate organizations to encourage those entities, when feasible, to provide the treating practitioner's specialty/credentials to signed progress/consult/operative notes.

703. CERTIFIED TRANSLATION AND INTERPRETER SERVICES
Introduced by Missouri

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-385.957

RESOLVED, That our American Medical Association work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and be it further

RESOLVED, That our AMA advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

704. PRIOR AUTHORIZATION ABUSE
Introduced by Washington

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-155.976, H-320.945, H-320.950, H-320.958, H-320.968 AND D-190.974 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association Board of Trustees continue proposing improvements to the prior authorization process to make it as efficient as possible and that prior authorization is only used for "outlier" medications, tests or treatments.

705. REGULATING HEALTH PLANS MEDICAL ADVICE
Introduced by Washington

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association define when medical advice is the practice of medicine; and be it further

RESOLVED, That our AMA study options for regulating medical advice given by health plans.

706. CONCURRENT AND OVERLAPPING SURGERY

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ALTERNATIVE RESOLUTION 706 ADOPTED IN LIEU OF RESOLUTION 706
See Policy H-475.981

RESOLVED, That our American Medical Association work with interested national medical specialty societies on issues related to concurrent and overlapping surgery.

707. INCLUSION OF CONTINUING CARE RETIREMENT CENTERS AND LONG-TERM CARE FACILITIES IN ACCOUNTABLE CARE ORGANIZATIONS INVESTMENT MODEL
Introduced by AMDA-The Society for Post-Acute and Long-Term Care Medicine

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association advocate to the Centers for Medicare & Medicaid Services to enable Continuing Care Retirement Centers and long-term care facilities and physicians working in those settings to initiate ACO Investment Models.

708. REMOVING 'THREE STAR MINIMUM' REQUIREMENT FOR SKILLED NURSING FACILITIES TO PARTICIPATE IN NEXT GEN ACCOUNTABLE CARE ORGANIZATIONS & BUNDLED PAYMENTS FOR CARE IMPROVEMENT PROGRAMS AND CARE FOR PATIENTS WITH WAIVER OF THREE NIGHT HOSPITAL STAY REQUIREMENT
Introduced by AMDA-The Society for Post-Acute and Long-Term Care Medicine

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association advocate to the Centers for Medicare & Medicaid Services to remove the three star quality requirement for skilled nursing facilities to participate in Next Gen Accountable Care Organizations and the Bundled Payments for Care Improvement programs with waiver of three night hospital stays for patients.

709. MANAGEMENT OF PHYSICIAN AND MEDICAL STUDENT STRESS
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ALTERNATIVE RESOLUTION 709 ADOPTED IN LIEU OF RESOLUTION 709
See Policy D-405.982

RESOLVED, That our American Medical Association produce a report on administrative and regulatory burdens placed on physicians, residents and fellows, and medical students, and pursue strategies to reduce these burdens.

710. PAYMENT FOR MEDICAID INTERPRETER SERVICES
Introduced by California

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-155.976, H-160.924, H-385.929, D-160.992 AND D-385.978 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support 1) access to interpreters for limited English proficient and hearing-impaired Medicaid patients; 2) regulations that require the Medicaid program and Medicaid managed care plans to arrange and pay for the services to relieve the burden on physicians; and 3) regulations that require physicians to be fully paid by the Medicaid program and Medicaid managed care plans for such services.

711. EXPANDING ACCESS TO SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; and be it further

RESOLVED, That our AMA support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and be it further

RESOLVED, That our AMA support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings.

712. PAY-FOR-PERFORMANCE INCENTIVES
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES H-155.960, H-165.838, H-390.849 AND H-450.947 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate with payers and other physician performance review organizations a new standard whereby performance incentives would be linked to the performance of the physician in providing and documenting appropriate advice on preventative care and self-care to patients and/or their parents and applicable incentives would be earned through delivery and documentation of appropriate advice that are considered equal to the performance incentive based on a clinical outcome; and be it further

RESOLVED, That our AMA work with any organization measuring physicians through incentive or performance programs to adopt standards that do not penalize physicians for the actions of patients who cannot or who will not comply with excellence in clinical recommendations.

713. URGE AMA TO RELEASE A WHITE PAPER ON ACOS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-160.923

RESOLVED, That our American Medical Association seek objective, independent data on Accountable Care Organizations and release a whitepaper regarding their effect on cost savings and quality of care.

714. TIMELY REFERRAL TO PAIN MANAGEMENT SPECIALIST
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association urge the Centers for Medicare and Medicaid Services and the Medicare Contractor Advisory Committee to endorse and adopt evidence-based clinical practice guidelines on the management and treatment of pain including but not limited to timely and appropriate referral to pain management specialists.

715. PRESCRIPTION AVAILABILITY FOR WEEKEND DISCHARGES
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-120.935

RESOLVED, That our American Medical Association work with pharmacy benefit managers (PBMs), health insurers, and pharmacists at a national level to address the problem of patients, discharged by a health care facility on a weekend or holiday, being denied access to vital medications because the patient's health insurance carrier or applicable PBM does not have staff available on weekends or holidays to resolve coverage and/or formulary issues; and be it further

RESOLVED, That these PBMs, health insurers and pharmacists are always available to resolve these issues of coverage and/or formulary on holidays and weekends to protect patient safety and prevent readmissions.

716. UNDERSTANDING AND CORRECTING IMBALANCES IN PHYSICIAN WORK ATTRIBUTABLE TO ELECTRONIC HEALTH RECORDS

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ALTERNATIVE RESOLUTION 716 ADOPTED IN LIEU OF RESOLUTION 716
See Policy D-478.966

RESOLVED, That our American Medical Association work with health care leaders and policymakers to use industrial engineering principles and evidence-based best practices to study and then propose systematic reforms to reduce physicians' electronic health record workload.

717. ALLOWING EXCEPTIONS TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES' LOCUM TENENS 60-DAY LIMIT
Introduced by Texas

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-405.981

RESOLVED, That our American Medical Association request that the Centers for Medicare & Medicaid Services (CMS) create an exception process to the 60-day locum tenens limit for those physicians with unforeseen circumstances, such as serious illness, physical impairment, or family emergency; and be it further

RESOLVED, That our AMA ensure that the exception process contains the same requirements as are necessary to currently bill under a CMS locum tenens arrangement.

718. DEVELOPING PHYSICIAN LEADERSHIP IN THE IMPLEMENTATION OF DIAGNOSTIC ERROR SURVEILLANCE
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association endorse the recommendations of the Improving Diagnosis in Health Care report published by the National Academy of Medicine in 2015; and be it further

RESOLVED, That our AMA support having physician satisfaction with administrative and support systems as a standard measure when assessing diagnostic error; and be it further

RESOLVED, That our AMA analyze from a policy perspective how best to position physicians in what may be increasing review of a physician's diagnostic skills; and be it further

RESOLVED, That our AMA report the findings of this analysis, and any recommendations based on these findings, at the 2018 Annual Meeting of the House of Delegates.

719. SYSTEM APPROACH TO MEDICAL STAFF GOVERNANCE
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-235.985

RESOLVED, That our American Medical Association provide guidance to medical staffs on the potential benefits and risks of applying a system approach to medical staff governance, including but not limited to guidance on instituting system-wide processes and leadership structures and otherwise standardizing medical staff bylaws.

720. MEDICAL STAFF NON-PUNITIVE REPORTING PROCESSES
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-235.984

RESOLVED, That our American Medical Association provide guidance, including but not limited to model medical staff bylaws language, to help medical staffs develop and implement reporting procedures that effectively protect medical staff members from retaliation when they report deficiencies in the quality, safety, or efficacy of patient care.

721. SECRET BALLOTS IN MEDICAL STAFF VOTING PROCESSES
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-235.983

RESOLVED, That our American Medical Association advocate for the use of secret ballots by medical staffs in all decision-making matters where voting members of the medical staff may be unwilling to publicly vote due to employer or other pressures that could impact how individual members vote; and be it further

RESOLVED, That our AMA provide guidance to help organized medical staffs develop and implement secret balloting processes, including specific procedures that allow for individual members of the medical staff to confidentially request a vote by secret ballot; and be it further

RESOLVED, That our AMA support the inclusion of provisions for secret balloting and confidential requests for secret balloting in model medical staff bylaws.