RESOLUTION 001 – EXPANDING THE AMA-MSS GOVERNING COUNCIL TO INCLUDE A DIVERSITY, EQUITY, AND INCLUSION OFFICER

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS expands its Governing Council to include an annually elected Diversity, Equity, and Inclusion Officer empowered to and charged with the sustainable prioritization of these values within our section; and be it further

RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

Internal Operating Procedures (Various Sections)

4.1 Designations. The officers of the MSS shall be the eight nine Governing Council members: Chair, Vice Chair, AMA Delegate, Alternate Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker,—and Vice Speaker, and Diversity, Equity, & Inclusion Officer. The Chair-elect/Immediate Past Chair shall be non-voting members of the Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker.

4.4.6 Diversity, Equity, & Inclusion Officer: The Diversity, Equity, & Inclusion Officer shall:

4.4.8.1 Coordinate the AMA-specific activities of the identity-based National Medical Student Organization liaisons (as defined in MSS IOPs 10.3.3), identity-based Professional Interest Medical Association liaisons (as defined in MSS IOPs 10.3.2), and identity-based AMA-MSS Standing Committees within the Section.
4.4.8.2 Serve as a liaison between the AMA's Center for Health Equity, the MSS, and the MSS Governing Council.
4.4.8.3 Serve as a liaison between identity-based National Medical Student Organization leadership and the Section.
4.4.8.4 Support the functions of the MSS liaisons to the Minority Affairs Section (MAS), the Women Physicians Section (WPS), the Advisory Committee on LGBTQ issues, and other identity-based sections or groups within the AMA.
4.4.8.5 Track demographics in the Section and direct efforts to recruit and retain a more diverse and representative AMA-MSS membership and leadership.
4.4.8.6. Develop and maintain a culture of inclusivity and allyship within the Section.
6.7.3 First Ballot. At the Interim Meeting, one ballot shall be used by the credentialed MSS Delegate to cast one vote for the Chair-elect and one vote for the Medical Student Trustee. At the Annual Meeting, individual ballots for each position shall be used by the credentialed MSS Delegate to cast one vote for each of the four positions: the Vice Chair, AMA Delegate, At-Large Officer, and Speaker, and Diversity, Equity, & Inclusion Officer. No ballot should be counted if there is more than one vote for a position. All Governing Council positions will be determined by majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast.

6.8 Endorsements for Diversity, Equity, & Inclusion Officer. Given the importance of ensuring the Diversity, Equity, & Inclusion Officer represents diverse groups, candidates for this position may seek endorsements of their candidacy from the identity-based standing committees, liaisons to identity-based National Medical Student Organizations (as defined in MSS IOPs 10.3.3), liaisons to Professional Interest Medical Association (as defined in MSS IOPs 10.3.2) and liaisons to identity-based AMA Sections and Advisory Committees (as defined in AMA Bylaw 7.0.1).

6.8.1 Candidates are strongly encouraged to seek at least one endorsement, and may seek as many endorsements as they choose.
6.8.2 Committees and liaisons may endorse as many candidates as they choose. Committees and liaisons shall create internal guidelines centered around lived experiences and personal diversity by which to determine endorsements.

RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

6.5.7.3 No mode of MSS- or AMA-sponsored communication, including, but not limited to listservs, phone or email lists, or other mass communication methods shall be used for announcements of candidacy, endorsement, or campaigning unless otherwise outlined in these IOPs.

RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

6.5.9.1 Only MSS members may be involved in a candidate’s campaign. MSS members should not share their opinion in favor of or in opposition to any candidate while acting under any official leadership role within or outside of the organization unless otherwise outlined in these IOPs.

RESOLVED, That our AMA-MSS amends its Internal Operating Procedures as follows:

6.7.2 Voting Periods. There shall be one voting period at the Interim Meeting for the selection of the Chair-elect and Medical Student
Trustee. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, AMA Delegate, At-Large Officer, and Speaker, and Diversity, Equity, & Inclusion Officer. An additional balloting period will be held for the elections of the Alternate Delegate and Vice Speaker.

; and be it further

RESOLVED, That our AMA-MSS Governing Council, with input from AMA-MSS identity-based Standing Committees and National Medical Student Organization liaisons, appoint an individual at the AMA-MSS 2021 Interim Business Meeting to serve as an interim Diversity, Equity, & Inclusion Officer, who will be fully empowered as a member of the Governing Council but not be allowed to vote until elected by the Section, until the AMA-MSS 2022 Annual Business Meeting election can occur.

RESOLUTION 002 – IMPROVING ACCESS TO TELEHEALTH FOR THOSE WITH DISABILITIES

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA utilize virtual platforms that are accessible to all members, including those with hearing or visual impairment, by using resources such as closed-captioning, magnification, and screen readers; and be it further

RESOLVED, That our AMA-MSS support policy ensuring technology companies produce telemedicine software/products that are accessible to persons with disabilities and in-line with the interpretation that the ADA’s use of the phrase “public accommodation” is not limited to physical structures and may be extended to virtual spaces; and be it further

RESOLVED, That AMA amend Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992 by addition as follows; and be it further

Preserving Protections of the Americans with Disabilities Act of 1990, D-90.992

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians and institutions make their offices and telemedicine platforms more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

RESOLVED, That AMA amend Enhancing Accommodations for People with Disabilities H-90.971 by addition as follows:
H-90.971 – ENHANCING ACCOMMODATIONS FOR PEOPLE WITH DISABILITIES
Our AMA encourages physicians to make their offices both physically and virtually accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

RESOLUTION 003 – MEDICAL HONOR SOCIETY INEQUITIES AND REFORM

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA recognize that demographic and socioeconomic inequities exist in medical student membership in medical honor societies; and be it further

RESOLVED, That our AMA study reforms to mitigate demographic and socioeconomic inequities in the selection of medical students for medical honor societies, including Alpha Omega Alpha and the Gold Humanism Honor Society, as well as the implications of ending the selection of medical students to these societies on equity in the residency application process and report back by the November 2021 HOD meeting; and be it further

RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the June 2021 Special Meeting.

RESOLUTION 004 – USE OF NON-POLICE MENTAL HEALTHCARE WORKER TEAMS TO RESPOND TO APPROPRIATE 911 CALLS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS supports the expansion and funding of non-police emergency behavioral health specialists and/or co-behavioral health specialists and police officer emergency dispatch teams where appropriate, and in compliance with the non-police team’s standards for team safety, to respond to mental health crisis calls.

RESOLUTION 005 – OPPOSITION TO SOBRIETY REQUIREMENT FOR HEPATITIS C TREATMENT

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA amend policy H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment, by addition and deletion 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 removal of sobriety
requirements as a barrier to HCV treatment; (5) work with state medical societies to remove sobriety requirements for HCV treatment; (46) support programs aimed at training providers in the treatment and management of patients infected with HCV; (57) 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; (68) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (79) encourage equitable reimbursement for those providing treatment.

RESOLUTION 006 – MEDICARE ELIGIBILITY AT AGE 60

MSS ACTION: ADOPT

RESOLVED, That our AMA advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to 60; and be it further

RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the June 2021 Special Meeting.

RESOLUTION 007 – PEDIATRIC MENTAL HEALTH NEEDS DURING PANDEMICS AND CRISES

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS supports and encourages the research of longitudinal mental health effects of pandemics and other disasters on the pediatric population.

RESOLUTION 008 – RECTIFYING THE INEQUITABLE AND RACIST EFFECTS OF “THE FLEXNER REPORT”

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS (1) recognize the harm created and sustained by the adoption of “The Flexner Report” and (2) create, distribute, and/or promote materials that educate about this history; and be it further

RESOLVED, That our AMA-MSS support the creation of a task force, with representation from stakeholders within and beyond the AMA, to guide our organization’s work to promote truth, reconciliations, and healing in medicine and medical education; and be it further

RESOLVED, That our AMA-MSS support funding to support the creation and sustainability of Historically Black College and University (HBCU) and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and be it further
RESOLVED, That our AMA-MSS support the study of the possibility of including an antiracism competency as part of graduation requirements for LCME- and COCA-accredited medical schools as well as ACGME-accredited residency programs.

RESOLUTION 009 – PROMOTING EQUITY IN GLOBAL VACCINE DISTRIBUTION
RESOLUTION 037 – ADVOCATING FOR FEDERAL INVOLVEMENT IN PLANNING AND STRATEGIZING A GLOBAL COVID-19 VACCINE DISTRIBUTION PLAN

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA amend policy H-250.988, “Low-Cost Drugs to Poor Countries during Times of Pandemic Health Crises,” by addition and deletion as follows:

H-250.988 – AID LOW-COST DRUGS TO POOR LOW- AND MIDDLE-INCOME COUNTRIES DURING EPIDEMICS AND PANDEMICS TIMES OF PANDEMIC HEALTH CRISSES

Our AMA will: (1) encourages pharmaceutical companies to work with governmental and appropriate regulatory authorities to encourage (a) the prioritization of equity when providing low cost or free medications, including therapeutics and vaccines, to countries; (b) the temporarily waiver of intellectual property protections for necessary medications and other countermeasures; and (c) sharing of equipment, materials, scientific methods, and technological information, to facilitate production and distribution of necessary medications during epidemics and pandemics times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAIDS, and similar organizations that provide comprehensive assistance, including health care, to low- and middle-income countries in an effort to improve public health and national stability.

RESOLVED, That our AMA-MSS immediately forward this resolution to the AMA House of Delegates.

RESOLUTION 010 – AMEND D-95.987, TO SUPPORT EXEMPTING FENTANYL TEST STRIPS AND OTHER DRUG CHECKING TECHNOLOGIES FROM PARAPHERNALIA LAWS
RESOLUTION 024 – AMEND H-95.958, TO DECRIMINALIZE IDPE IN SAFE SYRINGE PROGRAMS

MSS ACTION: SUBSTITUTE RESOLUTION 010 BE ADOPTED IN LIEU OF RESOLUTION 010 AND RESOLUTION 024

RESOLVED, That our AMA-MSS will ask the AMA to amend policy D-95.987 by addition and deletion as follows:

D-95.987 – PREVENTION OF OPIOID DRUG-RELATED OVERDOSE
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse substance use disorders (SUDs) and drug-related overdoses and death places on patients and
society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (B) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

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

3. Our ASA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from opioid addiction and their friends/families that address harm reduction measures and how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

4. Our ASA will advocate for, and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed to support safe use of drugs, including drug contamination testing and injection drug preparation, use, and disposal supplies.

RESOLUTION 011 – INCREASING SUPPORT FOR DOULA SERVICES TO REDUCE MATERNAL MORTALITY

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS support Medicaid coverage for doulas services.

RESOLUTION 012 – ABOLISHMENT OF THE RESOLUTION COMMITTEE

MSS ACTION: ADOPT

RESOLVED, That our AMA abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, “Resolution Committee,” as follows by deletion:

Resolution Committee, B-2.13.3
The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.
2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.

2.13.3.2 Size. The committee shall consist of a maximum of 31 members.

2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.

2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.

2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.

2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.

2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

RESOLUTION 013 – OPPOSING THE USE OF VULNERABLE INCARCERATED PEOPLE IN RESPONSE TO PUBLIC HEALTH EMERGENCIES OF INFECTIOUS DISEASE ORIGIN

MSS ACTION: REFER FOR STUDY

RESOLVED, That our AMA oppose the inclusion of labor carried out by incarcerated people within epidemic and pandemic emergency response plans and/or as an impromptu measure.

RESOLUTION 014 – PROTECTION OF MEDICAL STUDENTS THAT ADVOCATE SOCIAL JUSTICE

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS supports a physician-in-training’s First Amendment right to express opinions relating to medical issues; and be it further

RESOLVED, That our AMA-MSS oppose any institutional actions or policy that prevent or limit physician-in-training’s availability to advocate on behalf of patients’ interests or on behalf of good patient care, including direct or indirect institutional retaliation or disciplinary action; and be it further

RESOLVED, That our AMA-MSS encourage medical schools to explicitly enumerate policy pertaining to permitted student participation in lawful movements/protests within student conduct codes; and be it further

RESOLVED, That our AMA-MSS encourage medical schools and residency programs to blind applications to exclude arrests related to social justice movements and protests.
RESOLUTION 015 – POVERTY-LEVEL WAGES AND HEALTH

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty.

RESOLUTION 016 – MEDICARE ELIGIBILITY FOR INSULIN DEPENDENT PATIENTS

MSS ACTION: NOT ADOPT

RESOLUTION 017 – SUPPORT HARM REDUCTION EFFORTS THROUGH DECRIMINALIZATION OF POSSESSION OF NON-PRESSCRIBED BUPRENORPHINE

MSS ACTION: ADOPT

RESOLVED, That our AMA advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic; and be it further

RESOLVED, That our AMA support any efforts to decriminalize the possession of non-prescribed buprenorphine.

RESOLUTION 018 – ADDRESSING LOW VACCINATION RATES AMONG MINORITIES THROUGH TRUST-BUILDING AND ELIMINATION OF FINANCIAL BARRIERS


H-350.957 – ADDRESSING IMMIGRANT HEALTH DISPARITIES
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

H-440.860 – FINANCING OF ADULT VACCINES: RECOMMENDATIONS FOR ACTION
1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.

2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related
a. Develop a data-driven rationale for improved vaccine administration fees.
b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related
a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding. 
c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.
State-related
a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related
1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
c. Improve accountability by adopting performance measurements.
d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including startup costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related
Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.
3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

H-440.992 – NATIONAL IMMUNIZATION PROGRAM
Our AMA believes the following principles are required components of a national immunization program and should be given high priority by the medical profession and all other segments of society interested and/or involved in the prevention and control of communicable disease: (1) All US children should receive recommended vaccines against diseases in a continuing and ongoing program.
(2) An immunization program should be designed to encourage administration of vaccines as part of a total preventive health care program, so as to provide effective entry into a continuous and comprehensive primary care system.
(3) There should be no financial barrier to immunization of children.
(4) Existing systems of reimbursement for the costs of administering vaccines and follow-up care should be utilized.
(5) Any immunization program should be either (a) part of a continuing physician/patient relationship or (b) the introductory link to a continuing physician/patient relationship wherever possible.
(6) Professionals and allied health personnel who administer vaccines and manufacturers should be held harmless for adverse reactions occurring through no fault of the procedure.

(7) Provision should be made for a sustained, multi-media promotional campaign designed to educate and motivate the medical profession and the public to expect and demand immunizations for children and share responsibility for their completion.
(8) An efficient immunization record-keeping system should be instituted.

RESOLUTION 019 – ENVIRONMENTAL CONTRIBUTORS TO DISEASE AND ADVOCATING FOR ENVIRONMENTAL JUSTICE

MSS ACTION: ADOPT
RESOLVED, That our AMA amend Policy D-135.997, “Research into the Environmental Contributors to Disease,” by addition and deletion to read as follows:

D-135.997 – RESEARCH INTO THE ENVIRONMENTAL CONTRIBUTORS TO DISEASE AND ADVOCATING FOR ENVIRONMENTAL JUSTICE

Our AMA will (1) advocate for the greater public and private funding for research into the environment causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address an remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

RESOLUTION 020 – INCREASE EMPLOYMENT SERVICES FUNDING TO PEOPLE WITH DISABILITIES

MSS ACTION: ADOPT

RESOLVED, That our AMA support increased resources for employment services to reduce health disparities for people with disabilities.

RESOLUTION 021 – ADDRESSING SEXUAL ASSAULT ON COLLEGE CAMPUSES

MSS ACTION: REAFFIRM H-515.956 AND H-515.952

H-515.956 – ADDRESSING SEXUAL ASSAULT ON COLLEGE CAMPUSES

Our AMA: (1) supports universities’ implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.

H-515.952 – ADVERSE CHILDHOOD EXPERIENCES AND TRAUMA-INFORMED CARE

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research, and evaluation of cost-effective ACE screening tools without additional burden for physicians;
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACE screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life.

RESOLUTION 022 – NEED FOR INCREASED DIVERSITY IN STANDARDIZED PATIENTS

MSS ACTION: REAFFIRM H-295.987 AND H-295.874

H-295.897 – ENHANCING THE CULTURAL COMPETENCE OF PHYSICIANS
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. 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.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

H-295.874 – EDUCATING MEDICAL STUDENTS IN THE SOCIAL DETERMINANTS OF HEALTH AND CULTURAL COMPETENCE
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, cultural competence, and meeting the needs of underserved populations the undergraduate medical
school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students’ appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

RESOLUTION 023 – UNIVERSITY LAND GRANT STATUS IN MEDICAL SCHOOL ADMISSIONS

MSS ACTION: ADOPT

RESOLVED, That our AMA work with the Association of American Medical Colleges (AAMC), Liaison Committee on Medical Education (LCME), Association of American Indian Physicians, and the Association of Native American Medical Students to design and promulgate medical school’s admissions recommendations in line with the federal trust responsibility; and be it further

RESOLVED, That our AMA amend H-350.981 by addition to read as follows:

H-350.981 – AMA SUPPORT OF AMERICAN INDIAN HEALTH CAREER OPPORTUNITIES
AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees.
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a greater number of additional health professionals to work among the American Indian population.

(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

(6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI-AN communities.

RESOLUTION 025 – STUDYING POPULATION-BASED INSURANCE AND PAYMENT POLICY DISPARITIES

MSS ACTION: REFER FOR STUDY

RESOLVED, That our AMA oppose insurance and payment policy disparities that impact physicians in different specialties who treat distinct patient populations but provide similar services for these distinct patient populations, as well as insurance and payment policy disparities for similar care performed on distinct population; and be it further

RESOLVED, That our AMA work with the CPT Editorial Panel, the AMA/Specialty Society RVS Update Committee (RUC) and other relevant stakeholders to study the allocation of RVUs and the creation of CPT codes for services performed by specialties that predominantly serve historically underserved populations (including, but not limited to, pediatrics, obstetrics and gynecology, geriatrics, and psychiatry) and potential effects of such allocation methods on health disparities associated with race, socioeconomic status, gender, age, and other demographic factors to address root structural causes for reimbursement disparities, and report back to the House of Delegates; and be it further

RESOLVED, That our AMA work with the CPT Editorial Panel, the RUC, and other relevant stakeholders to address potential insufficiencies in coding and relative valuation for care performed for underserved populations and report back to the House of Delegates.

RESOLUTION 026 – ESTABLISHING COMPREHENSIVE DENTAL BENEFITS UNDER STATE MEDICAID PROGRAMS

MSS ACTION: ADOPT AS AMENDED
RESOLVED, That our AMA amend H-330.872, “Medicare Coverage for Dental Services” by addition and deletion as follows:

H-330.872 - MEDICARE, MEDICAID, AND OTHER PUBLIC HEALTH INSURANCE COVERAGE FOR DENTAL SERVICES
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare, Medicaid, and other public health insurance program beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among Medicare, Medicaid, and other public health insurance program beneficiaries populations, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in both Medicare, Medicaid, and other public health insurance program beneficiaries populations, and the impact of expanded dental coverage on health care costs and utilization.

RESOLUTION 027 – INCREASING TRANSPARENCY IN THE MSS POLICY PROCESS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, To improve institutional memory, our AMA-MSS amend policy 645.031MSS, “Policy-Making Procedures” as follows:

645.031MSS – POLICY-MAKING PROCEDURES
A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students.

RESOLUTION 028 – AMEND H-60.965, TO ADDRESS ADOLESCENT TELEHEALTH CONFIDENTIALITY CONCERNS

MSS ACTION: REAFFIRM H-60.965 AND H-160.937

H-60.965 – CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS
Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the
adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;

(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);

(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;

(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;

(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;

(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and

(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

H-160.937 – THE PROMOTION OF QUALITY TELEMEDICINE

1. The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used:

A. The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine.

B. Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances.

C. Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized.

D. The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting.
E. Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services.
F. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.
G. Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians.
H. The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians.

2. The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions.

3. The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality.

4. The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Accreditation Criteria of the Accreditation Council for Continuing Medical Education.

5. Our AMA supports the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians.

RESOLUTION 029 – MITIGATING THE IMPACT OF AIR POLLUTION ON PEDIATRIC HEALTH

MSS ACTION: REFER FOR STUDY, REAFFIRM H-135.996, H-135.998, AND H-135.999 IN LIEU OF RESOLVE CLAUSES 1-3

Refer:
RESOLVED, That in order to reduce sources of diesel exhaust surrounding schools, our AMA amends policy D-135.996 as follows:

D-135.996 – REDUCING SOURCES OF DIESEL EXHAUST
Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small
non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA’s proposal to roll back the “glider Kit Rule” which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards; and (5) Ask the U.S. Department of Education to work with state and local leaders, and appropriate stakeholders to advocate for the transition from diesel to electric (zero-emission) or retrofitted (reduced-emission) school buses.

Reaffirm:

H-135.996 – POLLUTION CONTROL AND ENVIRONMENTAL HEALTH
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

H-135.998 – AMA POSITION ON AIR POLLUTION
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.
(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.
(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.
(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

H-135.999 – FEDERAL PROGRAMS
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry, and the public. Current progress in the control of air pollution can be attributed primarily to such
cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.

RESOLUTION 030 – OPPOSING FORCED HYSTERECTOMIES AND REPRODUCTIVE MISTREATMENT OF ICE DETAINEES AND BIPOC INDIVIDUALS


D-350.983 – IMPROVING MEDICAL CARE IN IMMIGRANT DETENTION CENTERS
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) 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 (3) advocate for access to health care for individuals in immigration detention.

H-350.957 – ADDRESSING IMMIGRANT HEALTH DISPARITIES
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

D-430.997 – SUPPORT FOR HEALTH CARE SERVICES TO INCARCERATED PERSONS
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care
services, including mental health services, delivered to the nation’s correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

H-350.955 – CARE OF WOMEN AND CHILDREN IN FAMILY IMMIGRATION DETENTION
1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.

RESOLUTION 031 – AMENDING POLICY D-350.983, TO INCLUDE COMMUNITY PHYSICIAN OVERSIGHT


D-160.921 – PRESENCE AND ENFORCEMENT ACTIONS OF IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE) IN HEALTHCARE
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE)
enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

D-65.992 – MEDICAL NEEDS OF UNACCOMPANIED, UNDOCUMENTED IMMIGRANT CHILDREN

1. Our AMA will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.

2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.

3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.

4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.

H-350.957 – ADDRESSING IMMIGRANT HEALTH DISPARITIES

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
H-60.906 – OPPOSING THE DETENTION OF MIGRANT CHILDREN
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.

270.041MSS – SUPPORTING EXTERNAL ACCOUNTABILITY FOR ICE AND CBP
AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection.

65.039MSS – ADVOCATING FOR ALTERNATIVES TO IMMIGRANT DETENTION CENTERS THAT RESPECT HUMAN DIGNITY
Our AMA-MSS will ask our AMA to advocate for the preferential use of community-based, non-custodial Alternatives to Detention programs within the United States that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.

RESOLUTION 032 – INCREASING ACCESS TO INNOVATIVE GLUCOSE MONITORING FOR ALL DIABETICS

MSS ACTION: ADOPT AS AMENDED
RESOLVED, That our AMA advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors; and be it further
RESOLVED, That our AMA amend policy H-330.885 by addition and deletion as follows:

H-330.885 – MEDICARE PUBLIC INSURANCE COVERAGE OF CONTINUOUS GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN-DEPENDENT DIABETES
Our AMA supports efforts to achieve Medicare coverage of continuous and flash glucose monitoring systems for all diabetic patients with diabetes with insulin-dependent diabetes by all public insurance programs.
RESOLUTION 033 – STUDYING MORTALITY AMONG HOMELESS POPULATIONS

MSS ACTION: NOT ADOPT

RESOLUTION 034 – EVIDENCE-BASED GUIDELINES FOR CORNEAL DONATION FOR MEN WHO HAVE SEX WITH MEN

MSS ACTION: SUBSTITUTE RESOLUTION 034 BE ADOPTED WITH A TITLE CHANGE IN LIEU OF RESOLUTION 034

Title: “Blood and Tissue Donor Deferral Criteria”

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

RESOLUTION 035 – DISAGGREGATION OF RACE DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT

MSS ACTION: ADOPT RESOLVES 1, 3, AND 4; REAFFIRM H-350.954 IN LIEU OF RESOLVE 2

RESOLVED, That our AMA add “Middle Eastern/North African (MENA)” as a separate race category on all AMA demographics forms; and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all surveys conducted by the U.S. Census Bureau, and for all federally funded research using race categories; and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all medical schools and residency demographics forms.

Reaffirm:

H-350.954 – DISAGGREGATION OF DEMOGRAPHIC DATA WITHIN ETHNIC GROUPS
1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b)
supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

RESOLUTION 036 – EQUITABLE REPORTING OF USMLE STEP 1 SCORES

MSS ACTION: SUBSTITUTE RESOLUTION 036 BE ADOPTED IN LIEU OF RESOLUTION 036

RESOLVED, That our AMA works with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit USMLE Step 1 or COMLEX Level 1 scores and students who received Pass/Fail scores.

RESOLUTION 038 – AMENDING H-420.978, ACCESS TO PRENATAL CARE, TO SUPPORT THE PRACTICE OF AN APPROPRIATE REIMBURSEMENT FOR GROUP PRENATAL CARE

MSS ACTION: REFER FOR STUDY

RESOLVED, Our AMA amend H-420.978 Access to Prenatal Care by addition and deletion as follows:

H-420.978 – ACCESS TO INDIVIDUAL AND GROUP PRENATAL CARE

(1) Our AMA supports development of legislation or other appropriate means to provide for access to and equitable reimbursement for individual and group prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual’s economic circumstances. (2) Our AMA will work with appropriate stakeholders and state medical associations to draft model legislation to ensure equitable Medicaid reimbursements for individual and group prenatal care in all states. (3) In developing such legislation, the our AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account.

RESOLUTION 039 – TOWARDS A COMPREHENSIVE PLAN TO LOWER DRUG PRICES WHILE PRESERVING INNOVATION

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS support a systematic plan to lower drug prices wherein a statutorily empowered authority would negotiate drug prices with manufacturers, prioritizing the most expensive medications, and be it further
RESOLVED, That our AMA-MSS support such an authority considering the following information during the course of a negotiation:

a) The comparative efficacy of the drug relative to the standard of care,
b) The unmet need of the disease(s) for which the drug is intended to treat,
c) The costs of the drug's development and manufacturing,
d) The amount of public investment used to develop the drug,
e) The prices charged for the drug in other peer countries if available, considering rebates, discounts, and other price modifications, and be it further

RESOLVED, That our AMA-MSS support that these negotiated prices would be used by all public and private insurance providers unless those providers choose to opt-out; and be it further

RESOLVED, That our AMA-MSS support the imposition of reasonable penalties to enforce pharmaceutical manufacturer compliance with negotiated prices; and be it further

RESOLVED, That our AMA-MSS support a ban on rebates from pharmaceutical manufacturers to pharmacy benefit managers or a requirement that the savings derived from a rebate must be passed on to insurance plan beneficiaries in their entirety.

RESOLUTION 040 – RECOMMENDING ALLYSHIP TRAINING IN MEDICAL EDUCATION

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS supports the inclusion of allyship trainings, which educate participants to use power and privilege to support individuals who experience oppression, in undergraduate, graduate, and continuing medical education.

RESOLUTION 041 – REPORTING OF PROGRAM-LEVEL DEMOGRAPHIC DATA TO FREIDA

RESOLUTION 054 – DATA DISCLOSURE ON PARENTHOOD DURING RESIDENCY

MSS ACTION: SUBSTITUTE RESOLUTION 041 ADOPTED IN LIEU OF RESOLUTION 041 AND RESOLUTION 054

RESOLVED, That our AMA-MSS study the topic of residency programs publishing and sharing with FREIDA demographic data, including but not limited to age, disability status, gender identity, Underrepresented in Medicine (URM) status, and LGBTQ+ status of their programs, as well as data on use of family planning policies in the residency program.

RESOLUTION 042 – MEDICAL STUDENT, RESIDENT, AND FELLOW SUICIDE REPORTING

MSS ACTION: REFER FOR STUDY

RESOLVED, That our AMA amend policy D-345.983 be amended by addition and deletion as follows:

D-345.983 – STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and
confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents, and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the confidential collection of pertinent suicide information of trainees in medical schools, residency, and fellowship programs, and current wellness initiatives that institutions have in place, to inform and promote meaningful mental health and wellness interventions in these populations; and (6) create a publicly accessible database that stratifies medical institutions based on relative rate of trainee suicide over a period of time, in order to raise awareness and promote the implementation of initiatives to prevent medical trainee suicide.

RESOLUTION 043 – GENERATION OF CPT CODES FOR TIME SPENT ON PRIOR AUTHORIZATION TO BETTER APPRECIATE PHYSICIAN BURDEN

MSS ACTION: NOT ADOPT

RESOLUTION 044 – INCLUSION OF HYGIENE PRODUCTS IN SUPPLEMENTAL NUTRITION PROGRAMS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA will support the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs; and be it further

RESOLVED, That our AMA advocate for federal legislation that increases access to menstrual hygiene products, especially for recipients of public assistance; and be it further

RESOLVED, That our AMA work with state medical societies to advocate for state legislation that increases access to menstrual hygiene products, especially for recipients of public assistance.
RESOLUTION 045 – ADVOCATING FOR THE DELIVERY OF STANDARDIZED PERINATAL CARE AND MONITORING OF HEALTHCARE OUTCOMES FOR INCARCERATED PREGNANT INDIVIDUALS

MSS ACTION: ADOPT AS AMENDED; REAFFIRM H-430.986 AND D-430.997

RESOLVED, That our AMA encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates; and be it further

RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process.

Reaffirm:

H-430.986 – HEALTH CARE WHILE INCARCERATED
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.

9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

D-430.997 – SUPPORT FOR HEALTH CARE SERVICES TO INCARCERATED PERSONS
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; (2) encourage all correctional systems to support NCCHC accreditation; (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost-effective and efficient methods to increase correctional health services funding; 4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities; (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and (6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

RESOLUTION 046 – ADDRESSING INEQUITY IN ONSITE WASTEWATER TREATMENT
MSS ACTION: REFER FOR STUDY, REAFFIRM D-440.924
Refer:
RESOLVED, That our AMA encourages federal, state, and local governments to recognize and address the problem of inadequate onsite wastewater treatment systems in order to reduce the risk of wastewater-related disease; and be it further

RESOLVED, That our AMA encourages federal, state, and local governments to abate financial and criminal penalties for insufficient wastewater management for individuals in order to reduce the perpetuation of systemic poverty and systemic racism.

Reaffirm:

D-440.924 – UNIVERSAL ACCESS FOR ESSENTIAL PUBLIC HEALTH SERVICES
Our AMA: (1) supports updating The Core Public Health Functions Steering Committee’s “The 10 Essential Public Health Services” to bring them in line with current and future public health practice; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation’s public health system.

RESOLUTION 047 – OPPOSE ONEROUS AND STRINGENT LIMITATIONS ON MEDICAL CLEARANCES

MSS ACTION: NOT ADOPT

RESOLUTION 048 – IMPLEMENTING PICTORIAL HEALTH WARNING ON ALCOHOLIC BEVERAGES FOR SALE IN CONTAINERS

MSS ACTION: NOT ADOPT

RESOLUTION 049 – IMG EXEMPTIONS FROM IMMIGRATION CAPS ON IMG-SPECIFIC IMMIGRATION CATEGORY FOR VISAS AND GREEN CARDS

MSS ACTION: REFER FOR STUDY
RESOLVED, That our AMA-MSS support the implementation of a healthcare worker visa category specifically for IMGs, which could ease post-visa foreign residence requirements and allow for appropriate visa travel guidelines to continue patient care; and be it further

RESOLVED, That our AMA-MSS support the creation of broad and accessible IMG-specific bridge programs between education-based and employment-based visas to increase retention of J-1 visa recipients who complete medical training in the US; and be it further

RESOLVED, That our AMA-MSS support the implementation of profession-specific or education-level exemptions for residents and physicians from the annual caps for EB-1,2 green cards and H1-B temporary work visas in order to decrease barriers of non-citizen International Medical Graduates from practicing in the US.

RESOLUTION 050 – IMPROVING PANDEMIC PREPAREDNESS IN THE PRECLINICAL YEARS

MSS ACTION: NOT ADOPT

RESOLUTION 051 – PROMOTING ORAL ANTICANCER DRUG PARITY

MSS ACTION: ADOPT AS AMENDED BY SUBSTITUTION

RESOLVED, That our AMA amend H-55.986, Home Chemotherapy and Antibiotic Infusions by addition and deletion as follows:

H-55.986 – HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS
Our AMA: (1) endorses the use of home medications to include those orally-administered, injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians’ recommendation and supervision; (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; (4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate reimbursement policies for home infusions; and (6) opposes any requirement by insurers for home administration of drugs, if in the treating physician’s clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated
with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings; and (7) advocates for patient cost-sharing parity between office- and home-administered anticancer drugs.

RESOLUTION 052 – AMEND AMA POLICY H-70.912, TO RECOMMEND THE USE OF “INTELLECTUAL DISABILITY” IN LIEU OF “MENTAL RETARDATION” IN ACADEMIC TEXTS, PUBLISHED LITERATURE, AND MEDICAL EDUCATION

MSS ACTION: REAFFIRM H-70.912

H-70.912 – ELIMINATING THE USE OF THE TERM “MENTAL RETARDATION” BY PHYSICIANS IN CLINICAL SETTINGS
Our AMA recommends that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings.

RESOLUTION 053 – ADVOCATING FOR MODERN SOLUTIONS TO ADDRESS FOOD INSECURITY IN SCHOOL-AGED CHILDREN

MSS ACTION: REAFFIRM H-150.962

H-150.962 – QUALITY OF SCHOOL LUNCH PROGRAM
1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.

RESOLUTION 055 – RACIAL BIAS IN MEDICAL TECHNOLOGY

MSS ACTION: REAFFIRM H-65.952

H-65.952 – RACISM AS A PUBLIC HEALTH THREAT
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of
systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

RESOLUTION 056 – ONLINE MEDICAL SCHOOL INTERVIEW OPTION

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long term success, and well-being of students/residents.

RESOLUTION 057 – AMENDING TO ADD RACIAL EQUITY FOR H-130.954, NON-EMERGENCY PATIENT TRANSPORTATION SYSTEMS


H-130.954 – NON-EMERGENCY PATIENT TRANSPORTATION SYSTEMS
Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

H-165.822 – HEALTH PLAN INITIATIVES ADDRESSING SOCIAL DETERMINANTS OF HEALTH
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

D-440.922 – FULL COMMITMENT BY OUR AMA TO THE BETTERMENT AND STRENGTHENING OF PUBLIC HEALTH SYSTEMS
Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.

H-350.953 – RACIAL HOUSING SEGREGATION AS A DETERMINANT OF HEALTH AND PUBLIC ACCESS TO GEOGRAPHIC INFORMATION SYSTEMS (GIS)
Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.

H-180.944 – PLAN FOR CONTINUED PROGRESS TOWARDS HEALTH EQUITY
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

RESOLUTION 058 – DEVELOPING A COMPREHENSIVE PLAN FOR HEALTH SYSTEMS REFORM

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS support the following vision for health systems reform as incremental steps toward a single payer system:
a) further expansion of fully refundable tax credits for patients to purchase individual insurance, including those intended to reduce premiums and those intended to reduce cost-sharing requirements,

b) elimination of the income cap for the determination of premium tax credit eligibility,

c) elimination of the requirement that patients need to lack access to affordable insurance through their employer or public insurance programs in order to qualify for premium tax credits,

d) encouraging expansion of options that allow employers to provide tax-exempt benefits for employees to enroll in an individual health plan of their choice,

e) federal requirements that healthcare insurance exchanges include personalized plan cost estimates to enhance price transparency and choice,

f) state and/or federal reinsurance programs to reduce the cost of insurance,

g) auto-enrollment in healthcare plans with the highest actuarial value for which prospective enrollees are eligible for coverage at no cost after the application of all relevant subsidies,

h) the establishment of an affordable public insurance option to be offered by the federal government without regard to income eligibility that achieves the following goals:
   i) expands access to high-quality health insurance coverage,
   ii) lowers costs for patients, including premiums and out-of-pocket costs,
   iii) only receives the subsidies available to competing insurers,
   iv) reimburses hospitals, physicians, and all other healthcare providers at rates sufficient to support their participation without imposing an undue financial burden on those providers,

i) all-payer rate negotiation as a means to reduce the cost of healthcare.

RESOLVED, That our AMA-MSS rescind policy 165.011MSS, “Medicaid Reform and Coverage for the Uninsured: Beyond Tax Credits”.

RESOLUTION 059 – ACCESS TO STANDARD CARE FOR NON-VIABLE PREGNANCY

MSS ACTION: ADOPT RESOLVE 2; REAFFIRM 5.001MSS AND 5.005MSS IN LIEU OF RESOLVE 1

RESOLVED, That our AMA-MSS opposes any hospital directive, policy, or legislation that may hinder patients’ timely access to the accepted standard of care in both emergent and non-emergent cases of non-viable pregnancy.

Reaffirm:

5.001MSS – PUBLIC FUNDING OF ABORTION SERVICES
AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable
service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding.

5.005MSS – MSS STANCE ON CHALLENGES TO WOMEN’S RIGHT TO REPRODUCTIVE HEALTH CARE ACCESS
AMA-MSS opposes legislation that would restrict a woman’s right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician’s ability to provide medical care.

RESOLUTION 060 – PROMOTION AND SUPPORT OF PHYSICIAN, STUDENT, AND PATIENT PARTICIPATION IN GOVERNMENT

MSS ACTION: REFER FOR STUDY

RESOLVED, That our AMA recognize voting as a dimension of public health; and be it further

RESOLVED, That our AMA formally support non-partisan voter registration in healthcare settings; and be it further

RESOLVED, That our AMA promote civic engagement among its members through actions including, but not limited to:
   a) Partnering with Civic Health Month or another stakeholder at the crossroads of civic engagement and health
   b) Disseminating non-partisan election information for national elections to its members
   c) Encourage its members to identify patients who may require additional assistance to vote in national elections; and be it further

RESOLVED, That our AMA encourage medical schools and entities employer healthcare professional to target and facilitate 100% eligible employee voter registration and participation.

RESOLUTION 061 – SUPPORTING THE FURTHER STUDY OF CATEGORY III SUNSCREEN INGREDIENTS

MSS ACTION: ADOPT

RESOLVED, That our AMA-MSS supports the study of the health effects of sunscreen ingredients currently available in the United States which have not been determined to be generally recognized as safe and effective.

RESOLUTION 062 – FORMAL TRANSITIONAL CARE PROGRAM FOR CHILDREN AND YOUTH WITH SPECIAL HEALTHCARE NEEDS

MSS ACTION: ADOPT

RESOLVED, That our AMA amend policy H-60.974, Children and Youth with Disabilities, by addition and deletion as follows, to strengthen our AMA policy and to include population of patients that do not fall under “disability” but also need extra care, especially when transitioning to adult health care, that they are currently not receiving due to a gap:
H-60.974 – CHILDREN AND YOUTH WITH DISABILITIES AND WITH SPECIAL HEALTH CARE NEEDS
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities and children and youth with special health care needs (CYSHCN); (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities and CYSHCN that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities and CYSHCN receive appropriate school health services; (5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities, and CYSHCN, and their families to plan and make the transition to the adult medical care system; (6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and (7) to encourage physicians to make their offices accessible to patients with disabilities and CYSHCN, especially when doing office construction and renovations.

RESOLUTION 063 – ADVOCATING FOR TAX INCENTIVES TO PROMOTE FOOD RECYCLING PROGRAMS TO REDUCE FOOD WASTE AND IMPROVE HEALTH

MSS ACTION: NOT ADOPT

RESOLUTION 064 – ADVOCATE FOR THE CREATION OF A NATIONAL ALL-PAYER CLAIMS DATABASE

MSS ACTION: REAFFIRM POLICY D-155.987

D-155.987 – PRICE TRANSPARENCY
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.

4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.

5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.

7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

RESOLUTION 065 – ADVOCATING FOR PLANT-BASED MEAT RESEARCH AND REGULATION

MSS ACTION: REFER FOR STUDY

RESOLVED, That our AMA supports plant-based meat research; and be it further

RESOLVED, That our AMA supports federal regulation and oversight of plant-based meat producers.

RESOLUTION 066 – PROPOSED CHANGE IN MENTAL HEALTH REPORTING AND TREATMENT OF PILOTS TO THE FAA

MSS ACTION: NOT ADOPT

RESOLUTION 067 – TAXATION AMENDMENT TO SPECIAL NEEDS TRUSTS FOR PATIENTS WITH HUNTINGTON’S DISEASE

MSS ACTION: REAFFIRM H-280.991

H-280.991 – POLICY DIRECTIONS FOR THE FINANCING OF LONG-TERM CARE
The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the
health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high-quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.

RESOLUTION 068 – EQUAL ACCESS AMONG THIRD PARTY RESOURCES

MSS ACTION: REAFFIRM H-305.925

H-305.925 – PRINCIPLES OF AND ACTIONS TO ADDRESS MEDICAL EDUCATION COSTS AND STUDENT DEBT
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.

12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined
baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA
successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short- and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment
information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

RESOLUTION 069 – INCREASING MEDICAID INSURANCE COVERAGE OF INFERTILITY SERVICES

MSS ACTION: REAFFIRM H-420.952 AND H-185.990

H-420.952 – RECOGNITION OF INFERTILITY AS A DISEASE
Our AMA supports 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.

H-185.990 – INFERTILITY AND FERTILITY PRESERVATION INSURANCE COVERAGE
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

RESOLUTION 070 – USE OF SITUATIONAL JUDGMENT AND PERSONALITY ASSESSMENTS IN MEDICAL SCHOOL ADMISSIONS

MSS ACTION: NOT ADOPT
RESOLUTION 071 – USMLE STEP EXAMINATION SCHEDULING DURING THE COVID-19 PANDEMIC


D-295.939 – INDEPENDENT REGULATION OF PHYSICIAN LICENSING EXAMS
Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).

H-275.934 – ALTERNATIVES TO THE FEDERATION OF STATE MEDICAL BOARDS RECOMMENDATIONS ON LICENSURE
Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for
taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean’s Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

D-275.958 – DISCOURAGING THE USE OF LICENSING EXAMS FOR INTERNAL PROMOTION IN MEDICAL SCHOOLS
It is the policy of the AMA to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase.

D-275.951 – USMLE AND COMLEX EXAMINATION FAILURES DURING THE COVID-19 PANDEMIC
Our AMA will advocate to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) that students at allopathic and osteopathic schools of medicine and residents in accredited residency programs in the United States scheduled between March 1, 2020 and May 31, 2021 to sit for any examination step/level in the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) sequence be allowed the opportunity to be re-examined, if they failed one of these examinations, one time at no additional charge to the student or resident.

RESOLUTION 072 – AMENDING D-440.985, HEALTH CARE PAYMENT FOR UNDOCUMENTED PERSONS, TO STUDY METHODS TO INCREASE HEALTH CARE ACCESS FOR UNDOCUMENTED IMMIGRANTS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA amend D-440.985, Health Care Payment for Undocumented Persons by addition as follows:

D-440.985 – HEALTH CARE PAYMENT FOR UNDOCUMENTED PERSONS
Our AMA: (1) shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level; and (2) support methods to increase health insurance access for undocumented immigrants, such as allowing them to purchase health insurance on the Affordable Care Act marketplaces.
RESOLUTION 073 – SUPPORTING ACCOUNTABLE ORGANIZATIONS TO RESIDENTS AND FELLOWS

MSS ACTION: ADOPT AS AMENDED

RESOLVED, That our AMA-MSS supports efforts to determine which organizations or governmental entities are best suited for being permanently responsible for and accountable to residents and fellows without conflicts of interest.

RESOLUTION 074 – PROMOTING THE INTEGRATION OF DIETITIANS INTO PRIMARY CARE TEAMS

MSS ACTION: REAFFIRM POLICY H-150.931 AND D-35.985

H-150.931 – PAYMENT FOR NUTRITION SUPPORT SERVICES
Our AMA recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports payment for the provision of their services.

D-35.985 – SUPPORT FOR PHYSICIAN LED, TEAM BASED CARE
Our AMA:
2. Will identify and review available data to analyze the effects on patients’ access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Will advocate to policymakers, insurers, and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation’s primary care workforce needs.
5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement
between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care” was premature; was not released officially; was not signed; and was not adopted by the participants.

RESOLUTION 075 – PROVIDING PATIENT ACCESS TO TRANSCRANIAL MAGNETIC STIMULATION FOR MENTAL HEALTH

MSS ACTION: NOT ADOPT

RESOLUTION 076 – AMEND POLICY H-480.945, “GENOME EDITING AND ITS POTENTIAL CLINICAL USE” TO ALIGN WITH AMA CODE OF MEDICAL ETHICS

MSS ACTION: REAFFIRM H-480.945

H-480.945 – GENOME EDITING AND ITS POTENTIAL CLINICAL USE
Our AMA (1) encourages continued research into the therapeutic use of genome editing; and (2) urges continued development of consensus international principles, grounded in science and ethics, to determine permissible therapeutic applications of germline genome editing.

RESOLUTION 077 – ADDRESSING HEALTHCARE DISPARITIES THROUGH PERSONALIZED MEDICINE AND IMPROVED REPRESENTATION OF ALL POPULATIONS IN HEALTHCARE EDUCATION AND TRAINING

MSS ACTION: NOT ADOPT

RESOLUTION 078 – MENTAL HEALTH SCREENING DURING ALL VISITS TO CLINICAL SETTINGS

MSS ACTION: REAFFIRM H-345.984

H-345.984 – AWARENESS, DIAGNOSIS, AND TREATMENT OF DEPRESSION AND OTHER MENTAL ILLNESSES
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy
groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs’ clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

4. Our AMA recognizes the impact of violence and social determinants on women’s mental health.

RESOLUTION 079 – SUPPORTING REVISION OF MEDICAL STUDENT GUIDELINES DURING HEALTHCARE CRISSES

MSS ACTION: REAFFIRM H-295.995

H-295.995 – RECOMMENDATIONS FOR FUTURE DIRECTIONS FOR MEDICAL EDUCATION
Our AMA supports the following recommendations relating to the future directions for medical education:

(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.

(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.

(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.

(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.

(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.

(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete
courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.

(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.

(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.

(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.

(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.

(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-
time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included.

(17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not
be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant’s knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician’s professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified, as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and
evaluation while recognizing the contribution of non-physicians to medical education.

(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

RESOLUTION 080 – MENTAL HEALTH REFORM IN PRISONS

MSS ACTION: REFER FOR STUDY, REAFFIRM H-430.986

Refer:
RESOLVED, That our AMA supports conducting mental health screening of all individuals entering or re-entering the prison system in order to improve diversion practices as well as treatment access.

Reaffirm:

H-430.986 – HEALTH CARE WHILE INCARCERATED
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective
upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

RESOLUTION 081 – CLINICAL OPPORTUNITIES FOR UNMATCHED MEDICAL STUDENTS

MSS ACTION: NOT ADOPT

RESOLUTION 082 – ADDRESSING EARLY ADOLESCENT MENTAL HEALTH AND SOCIAL MEDIA

MSS ACTION: NOT ADOPT

RESOLUTION 083 – ADVOCATE FOR INTERNET SECURITY TRAINING FOR IMMIGRANT AND REFUGEE POPULATIONS

MSS ACTION: NOT ADOPT

LATE RESOLUTION 01 – EXPANDING SUPPORT FOR MEDICAL STUDENTS AND PHYSICIANS WITH DISABILITIES

MSS ACTION: REFER FOR STUDY

RESOLVED, That our AMA will prioritize the input, direction, and partnership of members with personal and lived experience of disability, especially those with intersecting marginalized identities, to ensure those most impacted guides the direction of change; and be it further

RESOLVED, That our AMA will collaborate with the relevant testing institutions to study and report back on the present barriers for applicants, medical students, and physicians with disabilities regarding admission, curricular, and licensing exams, and recommend practices that improve accessibility for and inclusion of those with disabilities; and be it further

RESOLVED, That our AMA will study and report back on persisting barriers to employment for physicians with disabilities, and recommend hiring and workplace practices (e.g. experienced
disability service offices) that improve accessibility for and inclusion of those with disabilities; and be it further

RESOLVED, That our AMA will collaborate with the Association of American Medical Colleges and The Coalition for Disability Access in Health Science Education to develop national standards for disability service providers (DSPs) that serve medical students, residents, and physicians, to ensure consistent training, practices, and availability of healthcare-specific DSPs.

LATE RESOLUTION 02 – MEDICAL MISINFORMATION IN THE AGE OF SOCIAL MEDIA

MSS ACTION: ADOPT

RESOLVED, That our AMA encourage social media organizations to further strengthen their content moderation policies related to medical misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; and be it further

RESOLVED, That our AMA encourage social media organizations to recognize the spread of medical misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; and be it further

RESOLVED, That our AMA continue to support the dissemination of accurate medical information by public health organizations and health policy experts; and be it further

RESOLVED, That our AMA work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical information; and be it further

RESOLVED, That our AMA amend existing policy concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation as follows:

D-440.921 – AN URGENT INITIATIVE TO SUPPORT COVID-19 VACCINATION INFORMATION PROGRAMS
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure
that the evidence continues to support safe and effective use of vaccines among recommended populations; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online; and be it further

RESOLVED, That our AMA study and consider public advocacy of modifications to Section 230(c) of the Communications Decency Act, Part 2, Clause A, as follows:

any action voluntarily taken in good faith to restrict access to or availability of material that the provider or user considers to be obscene, lewd, lascivious, excessively violent, harassing, pose risk to public health, or be otherwise objectionable, whether or not such material is constitutionally protected; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the June 2021 Special Meeting of the House of Delegates.

GC REPORT A – BIENNIAL REVIEW OF ORGANIZATIONS SEATED IN THE AMA-MSS ASSEMBLY

MSS ACTION: ADOPT AND FILE REPORT

Your MSS Governing Council recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA-MSS retains the following NMSSs and PIMAs as eligible for AMA-MSS Assembly representation: American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Association of Physicians of Indian Origin (AAPI), American College of Emergency Physicians (ACEP), American College of Medical Quality (ACMQ), American College of Physicians (ACP), American Society of Anesthesiologists (ASA), American Society of Military Surgeons of the US (AMSUS), American Medical Women’s Association (AMWA), Student Osteopathic Medical Association (SOMA), Psychiatry Student Interest Group Network (PsychSIGN), and Health Professionals Advancing LGBT Equality (GLMA).
2. That our AMA-MSS retains the following NMSOs as eligible for AMA-MSS Assembly representation: American Physician Scientists Association (APSA), Asian Pacific American Medical Student Association (APAMSA), Latino Medical Student Association (LMSA), and Student National Medical Association (SNMA), and Association of Native American Medical Students (ANAMS).
3. That our AMA-MSS recognize the following NMSS, NMSO and PIMA organizations as newly seated organizations in the AMA-MSS Assembly: Medical Student Pride Alliance (MSPA).

GC REPORT B – SUNSET REPORT

MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report be filed:

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.
2. That the AMA-MSS Governing Council review the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support.

3. That the language in the following policies be updated to industry-accepted, person-first language as indicated:
   a. 30.001MSS – “Alcoholism” be changed to “Substance Use Disorder,” and “addicted students” be changed to “students with substance use disorders.”
   b. 60.002MSS – “mother” be changed to “parent.”
   c. 65.010MSS – Add “or gender identity or expression” at the end of clause (4).
   d. 65.014MSS – Change “gay and lesbian” to “LGBTQ.”
   e. 95.001MSS – Change “abuse” to “misuse.”
   f. 95.002MSS – Change “abuse” to “misuse.”
   g. 100.007 – Change “Heroin” to “Opioid”; change “opiate addiction and abuse” to “opioid use disorder”; change “opiate addiction” to “opioid use disorder.”
   h. 160.031MSS – In clause (4), replace “his or her” with “their.”
   i. 170.016MSS – In clause (e), change “gay, lesbian, and bisexual” to “LGBTQ.”
   j. 180.008MSS – Change “same sex and opposite sex partners” to “domestic partners, regardless of gender.”
   k. 245.010MSS – Change “mothers” to “parents.”
   l. 270.004MSS – Change “his or her” to “their.”
   m. 270.028MSS – Change “Drug use and addiction” to “Substance Use Disorders”; update language from addiction and abuse to substance use disorders.
   n. 295.002MSS – Add “patients who are” in front of “deaf.”
   o. 295.035MSS – Add the word “made” to the end of the policy.
   p. 295.067MSS – Change “Rape Crises” to “Sexual Assault”; change “rape victims” to “survivors of sexual assault.”
   q. 295.104MSS – Change “his or her” to “their.”
   r. 295.150MSS – Add “and COMLEX” after “USMLE”
   s. 345.001MSS – Change “of Mental Patients” to “Patients with Psychiatric Disorders”; and “psychiatric patients” to “patients with psychiatric disorders.”
   t. 345.008MSS – Change “the Mentally Ill” to “person with psychiatric disorders” in the title and throughout policy.
   u. 350.011MSS – Add “medical” after “minority” and before “and premedical”
   v. 250.014MSS – Add “the Association of Native American Medical Students”
   w. 490.015MSS – Change “nicotine addiction” to “tobacco use disorder.”
   x. 630.007MSS – Change “Department of Medical Student Services” to “Medical Student Section.”
   y. 665.012MSS – In clause (3) replace “his or her” with “their.”

**DELEGATE REPORT C – TRANSMITTAL REPORT**

**MSS ACTION: ADOPT AND FILE REPORT**

Your Section Delegates recommend that the following resolutions be discharged from the transmittal queue, and that the remainder of the report be filed:

1. Expungement and Sealing of Drug Records
2. Report and Recommendations on the Residency Application Process
3. Encouraging Residency Program Collaboration to Allow Medical Students Fair and Equitable Application Process
4. Medical Licenses for Individuals with DACA Status
5. Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions
6. Recovery Homes Use of MOUD for Opioid Use Disorder

CEQM REPORT A – SUPPORT OF RESEARCH ON VISION SCREENINGS AND VISUAL AIDS FOR ADULTS COVERED BY MEDICAID

MSS ACTION: REFER FOR STUDY

Your Committee on Economics and Quality in Medicine recommends that the following recommendations be adopted in lieu of and the remainder of this report is filed:

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) appropriate scientific and medical to evaluate the value and feasibility of incorporating routine comprehensive eye exams and visual aids into the minimum mandatory benefits for Medicaid beneficiaries.

CGPH REPORT A – DECREASING YOUTH ACCESS TO E-CIGARETTES

MSS ACTION: ADOPT AND FILE REPORT

Your Committee on Global and Public Health recommends that the following resolve clause be adopted in lieu of formal supporting for existing HOD policy, and that the remainder of the report be filed:

RESOLVED, That our AMA-MSS support evidence-based policies at federal, state, and local levels that prevent e-cigarette use among youth, including, but not limited to:

1) Increased prices and/or taxes on e-cigarette products;
2) Clean air laws that restrict e-cigarette use in public places, such as schools;
3) Limitations on the number and location of e-cigarette retailers, and on where e-cigarette products are sold in stores;
4) Bans on flavored e-cigarette products;
5) Laws that reduce exposure to e-cigarette advertisements, such as on the internet and in TV and movies, magazines, and retail stores; and
6) Media campaigns that educate youth on the adverse effects of e-cigarette use.

CGPH REPORT B – INVESTIGATION OF NATUROPATHIC VACCINE EXEMPTIONS

MSS ACTION: ADOPT AND FILE REPORT

Your Committee on Global and Public Health recommends that the following resolve clause be adopted in lieu of the original resolution and the remainder of the report be filed.

RESOLVED, That our AMA opposes medical vaccine exemptions by non-physicians by amending H-440.970 Nonmedical Exemptions from Immunizations as follows:

H-440.970 – NON-MEDICAL EXEMPTIONS FROM IMMUNIZATIONS
1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the
health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (a) eliminate non-medical exemptions from mandated pediatric immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.

CGPH WIM REPORT A – INCREASING REGULATION OF NATURAL COSMETIC PRODUCTS

MSS ACTION: ADOPT AND FILE REPORT

Your Women in Medicine Committee and Committee on Global and Public Health recommend that the referred resolve clauses from MSS Resolution 056 not be adopted and the remainder of the report be filed.

CHIT CGPH REPORT A – MEDICAL MISINFORMATION IN THE AGE OF SOCIAL MEDIA

MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

Your Committee on Health Information Technology and Committee on Global and Public Health recommend the following recommendations are adopted, and the remainder of the report be filed:

RESOLVED, That our AMA encourage social media organizations to further strengthen the content moderation policies related to medical misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; and be it further

RESOLVED, That our AMA encourage social media organizations to recognize the spread of medical misinformation over dissemination networks and collaborate with relevant stakeholders
to address this problem as appropriate, including but not limited to, altering underlying network dynamics, or redesigning platform algorithms; and be it further

RESOLVED, That our AMA continue to support the dissemination of accurate medical information by public health organizations and health policy experts; and be it further

RESOLVED, That our AMA work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical information; and be it further

RESOLVED, That our AMA amend existing policy concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation as follows:

D-440.921 – AN URGENT INITIATIVE TO SUPPORT COVID-19 VACCINATION INFORMATION PROGRAMS
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 information and vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online.
; and be it further

RESOLVED, That our AMA study and consider public advocacy of modifications to Section 230(c) of the Communications Decency Act, Part 2, Clause A, as follows:

any action voluntarily taken in good faith to restrict access to or availability of material that the provider or user considers to be obscene, lewd, lascivious, excessively violent, harassing, pose risk to public health, or be otherwise objectionable, whether or not such material is constitutionally protected.

CME COLRP REPORT A – STUDY A NEED-BASED SCHOLARSHIP TO ENCOURAGE MEDICAL STUDENT PARTICIPATION IN THE AMA
MSS ACTION: ADOPT AND FILE REPORT

Your Committee on Long Range Planning and your Committee on Medical Education recommend the following:

1. That our AMA-MSS Governing Council, in collaboration with Region leadership and appropriate AMA staff members, will further explore barriers to medical student participation in the AMA, including, but not limited to, costs associated with AMA conference attendance, funding sources of delegates and other conference attendees, and needs not met by state medical societies; and

2. That our AMA-MSS will ask the AMA to explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences; and

3. The remainder of this report be filed.

CME MIC REPORT A – RESEARCH THE ABILITY OF TWO-INTERVAL GRADING OF CLINICAL CLERKSHIPS TO MINIMIZE RACIAL BIAS IN MEDICAL EDUCATION

MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

Your MSS Committee on Medical Education and MSS Minority Issues Committee recommend that the following recommendation be adopted and the remainder of the report be filed:

RESOLVED, That our AMA will study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency.

CME MIC REPORT B – EXCLUSION OF RACE AND ETHNICITY IN THE FIRST SENTENCE OF CASE REPORTS

MSS ACTION: ADOPT AND FILE REPORT

Your MSS Committee on Medical Education and MSS Minority Issues Committee recommend that the following resolve clauses from Resolution 063 be adopted and amended and the remainder of the report be filed:

RESOLVED, That our AMA encourages curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation; and be it further

RESOLVED, That our AMA encourages the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation.

COLRP CME REPORT A – UNDERSTANDING PHILANTHROPIC EFFORTS TO ADDRESS THE RISE OF MEDICAL SCHOOL TUITION

MSS ACTION: ADOPT AND FILE REPORT

Your Committee on Long Range Planning and your Committee on Medical Education recommend the following:

1. That our AMA-MSS study this topic every four years to gain a better understanding of the sustainability and impact of free and reduced medical tuition program including, but not limited to, debt burden beyond medical school, effects of debt on medical specialty choice,
as well as applicant diversity related to potential debt and release its findings in an informational report to the Assembly at A-25; and
2. The remainder of the report be filed.

CSI CGPH REPORT A – PROTECTION OF ANTIBIOTIC EFFICACY THROUGH WATER SYSTEM REGULATION

MSS ACTION: ADOPT AND FILE REPORT

Your Committee on Scientific Issues and Committee on Global and Public Health recommends the Resolution 061 not be adopted, and the remainder of the report is filed.

CSI CHIT REPORT A – INVESTIGATING THE IMPLEMENTATION OF ELECTRONIC IMMUNITY PASSPORTS FOR COVID-19 AND PUBLIC HEALTH EMERGENCIES

MSS ACTION: ADOPT AS AMENDED BY SUBSTITUTION AND FILE REPORT

RESOLVED, That our AMA-MSS amend 315.008MSS, “Against Immunity Passports to Relieve COVID-19 Restrictions,” by insertion and deletion as follows:

315.008MSS – AGAINST CONSIDERATIONS FOR IMMUNITY CREDENTIALS DURING PANDEMICS AND EPIDEMICS PASSPORTS TO RELIEVE COVID-19 RESTRICTIONS

Our AMA-MSS will ask the AMA to:

(1) oppose the implementation of natural immunity credentials, which give an individual differential privilege on the basis of natural immunity after non-vaccine exposure status to a pathogen, and
(2) caution that any implementation of vaccine-induced immunity credentials, which give an individual differential privilege on the basis of acquired immunity after receiving a vaccine, must strongly consider potential consequences on social inequity, including, but not limited to,

(i) continued marginalization of communities historically harmed or ignored by the healthcare system,
(ii) isolation of populations who may be ineligible for or unable to access vaccines,
(iii) barriers preventing immigration or travel from countries with low access to vaccines and the need to offer a vaccine upon arrival to anyone entering the US from another country, and
(iv) privacy of and accessibility to any systems used to implement vaccine-induced immunity passports.

; and be it further

RESOLVED, Our AMA-MSS immediately forward this recommendation to the AMA-HOD at the J-21 Special Meeting.

CSI COLA REPORT A – REGULATION OF PHTHALATES IN ADULT PERSONAL SEXUAL PRODUCTS
MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

Your Committee on Scientific Issues and Committee on Legislation and Advocacy recommend that AMA H-135.945 be amended by addition and deletion as follows, and the remainder of the report be filed:

H-135.945 – ENCOURAGING ALTERNATIVES TO PVC/PHTHALATE DEHP PRODUCTS IN HEALTH
Our AMA:
(1) Encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing phthalates such as Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and
(2) Urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing phthalates such as DEHP; and
(3) Encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal consumer products, including adult personal sexual products, as a source of phthalates; and
(4) Supports consumer education about the potential for exposure to toxic substances in adult personal sexual products.

CSI REPORT A – AMEND H-150.927 AND H-150.933, TO INCLUDE FOOD PRODUCTS WITH ADDED SUGAR

MSS ACTION: REFER FOR STUDY

Your Committee on Scientific Issues recommends that the following original resolve clauses be amended as follows, and the remainder of the report is filed:

RESOLVED, That our AMA amend H-150.927, “Strategies to Reduce the Consumption of Beverages with Added Sweeteners” by addition to read as follows:

H-150.927 – STRATEGIES TO REDUCE THE CONSUMPTION OF FOOD AND BEVERAGES WITH ADDED SWEETENERS
Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access
SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students.

RESOLVED, That our AMA amend H-150.933, “Taxes on Beverages with Added Sweeteners” as follows:

H-150.933 — STRATEGIES TO REDUCE THE CONSUMPTION OF BEVERAGES WITH ADDED SWEETENERS
1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages and food products containing added sweeteners. Taxes on beverages and food products with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.

2. Where taxes on beverages and food products with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.

3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages and food products, particularly in children and adolescents.

4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages and food products, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages and food products as requested.
CSI REPORT B – SUPPORTING DAYLIGHT SAVING TIME AS THE NEW, PERMANENT STANDARD TIME

MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

Your Committee on Scientific Issues recommends that the following recommendations are adopted and the remainder of the report is filed:

RESOLVED, That our AMA recognize the adverse health effects of biannual time changes and support the elimination of biannual time changing; and be it further

RESOLVED, That our AMA recognize the positive health effects of daylight savings time and support daylight savings time as the permanent standard time.

CSI REPORT C – IMPROVING THE LABELING OF OVER-THE-COUNTER MEDICATIONS BY INCLUDING CARBOHYDRATE CONTENT

MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

Your Committee on Scientific Issues recommends that the following resolve clause be adopted and the remainder of the report be filed:

RESOLVED, That our AMA-MSS supports the inclusion of carbohydrate content, in grams or micrograms, on labels for over-the-counter drugs.

LGBTQ+ REPORT A – THE IMPORTANCE OF CONSISTENT TERMINOLOGY FOR LGBTQ+ RELATED POLICY AND ASSESSMENT OF CURRENT AMA-MSS POLICY ON LGBTQ+ AFFAIRS

MSS ACTION: ADOPT AND FILE REPORT

Your Standing Committee on LGBTQ+ Affairs recommends the following resolve clauses be adopted and presents the remainder of this informational report for use by the Medical Student Section and recommends the report be filed.

RESOLVED, That our AMA-MSS will utilize the combined terminology recommendation and catalog of existing AMA-MSS policy to fully update existing AMA-MSS policy relating to LGBTQ+ Affairs to make it consistent with all other policies and the current best practices for language relating to the LGBTQ+ population; and be it further

RESOLVED, That our AMA-MSS amend 50.003MSS as follows:

**Blood Donation by HIV Negative Homosexual Males Men who have Sex with Men (MSM)**
AMA-MSS will ask the AMA to encourage the Food and Drug Administration to continue evaluation and monitoring of regulations on blood donation by men who have had sex with other men, and to consider making modifications to the current deferral policies if sufficient scientific evidence becomes available to support such a change.

RESOLVED, That our AMA-MSS amend 65.008MSS as follows:
Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population LGBTQ+ Community
AMA-MSS will ask the AMA to (1) encourage physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or perceived gender identity" in any nondiscrimination statement; and (2) encourage individual physicians to display for patient and staff awareness—-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or perceived gender identity."

RESOLVED, That our AMA-MSS amend 65.010MSS as follows:

Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender LGBTQ+ Health Issues on Medical School Campuses
AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities — without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender LGBTQ+ communities; (3) encourages the LCME to require all medical schools to incorporate GLBT LGBTQ+ health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation.

RESOLVED, That our AMA-MSS amend 65.014MSS as follows:

Marriage Equality and Repeal of the Defense of Marriage Act
(1) AMA-MSS will ask the AMA to support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting those gay and lesbian LGBTQ+ individuals and couples, their families, and their children; (2) AMA-MSS supports the repeal of the “Defense of Marriage Act,” as it discriminates against married same-sex couples and their families and directly contributes to health care disparities among the gay, lesbian, bisexual, and transgender (GLBT) LGBTQ+ community.

RESOLVED, That our AMA-MSS amend 65.015MSS as follows:

Reducing Suicide Risk among LGBTQ+ Lesbian, Gay, Bisexual, Transgender, and Questioning Youth through Collaboration with Allied Organizations
AMA-MSS will ask the AMA to partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning LGBTQ+ youth suicide and improve health among LGBTQ+ youth.

RESOLVED, That our AMA-MSS amend 65.017MSS as follows:
Lesbian, Gay, Bisexual, and Transgendered LGBTQ+ Patient-Specific Training Programs for Healthcare Providers
AMA-MSS will ask the AMA to support the training of healthcare providers in cultural competency as well as in physical health needs for lesbian, gay, bisexual, and transgender LGBTQ+ patient populations.

RESOLVED, That our AMA-MSS amend 65.024MSS as follows:

**FMLA-Equivalent for LGBTQ+ Workers**
AMA-MSS will ask the AMA to support the expansion of policies regarding family and medical leave to include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

RESOLVED, That our AMA-MSS amend 65.030MSS as follows:

**Sexual and Gender Minority Populations in Medical Research**
AMA-MSS will ask the AMA to amend policy H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation by insertion and deletion as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H-315.967
Our AMA: (1) supports the voluntary inclusion of a patient’s biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation/gender identity, sexual orientation, gender identity, and other sexual and gender minority traits, such as intersex or differences/disorders of sex development for the purposes of research into patient and population health.

RESOLVED, That our AMA-MSS amend 65.031MSS as follows:

**Oppose Requirements of Hormonal Treatments for Athletes**
AMA-MSS will ask the AMA to: (1) oppose any regulations requiring mandatory medical treatment or surgery for intersex athletes and/or athletes with Differences in Sex Development (DSD) to be allowed to compete in alignment with their identity; and (2) oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions.

RESOLVED, That our AMA-MSS amend 65.032MSS as follows:

**Patient-Reported Outcomes in Gender Affirming Confirmation Surgery**
AMA-MSS will ask the AMA to: (1) support initiatives and research to establish standardized protocols for patient selection, surgical management, and pre-operative and post-operative care for transgender patients undergoing gender affirming confirmation surgeries; and (2) support development and implementation of
standardized tools, such as questionnaires to evaluate outcomes of gender affirming confirmation surgeries.

RESOLVED, That our AMA-MSS amend 75.008MSS as follows:

Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use
AMA-MSS will ask the AMA to reaffirm its policy to reiterate that HIV and STD prevention education must be comprehensive to incorporate safer sex strategies including condom use, not just abstinence, and that these programs be culturally sensitive to the LGBTQ+ Community sexual orientation minorities.

RESOLVED, That our AMA-MSS amend 245.020MSS as follows:

Supporting Autonomy for Intersex Patients and Patients with Differences of Sex Development
AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in intersex patients and individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.

RESOLVED, That our AMA-MSS amend 295.190MSS as follows:

Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are LGBTQ+, Lesbian, Gay, Bisexual, Transgender, Gender Nonconforming, and/or Born with Differences of Sexual Development
Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age.

RESOLVED, That our AMA-MSS amend 295.191MSS as follows:

Educating Physicians About the Importance of Cervical Cancer Screening for Transgender Men Female-to-Male Transgender Patients
AMA-MSS will ask that our AMA amend policy H-160.991 by insertion and deletion to read as follows:

Healthcare Needs of LGBTQ+ Lesbian Gay Bisexual and Transgender Populations H- 160.991
Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women and transgender men female-to-male
transgender patients when medically indicated to undergo regular
cancer and sexually transmitted infection screenings due to their
comparable or elevated risk for these conditions; and (ii) the need
for comprehensive screening for sexually transmitted diseases in
men who have sex with men; and (iii) appropriate safe sex
techniques to avoid the risk of sexually transmitted diseases.

RESOLVED, That our AMA-MSS amend 130.041MSS as follows:
Improving Primary Care Residency Training to Advance
Health Care for LGBTQ+ Gay, Lesbian, Bisexual, and
Transgender Patients
AMA-MSS will ask the AMA to work with the Accreditation Council
for Graduate Medical Education and the American Osteopathic
Association to recommend to primary care residency programs that
they assess the adequacy and effectiveness of their curricula in
training residents on best practices for caring for LGBTQ+ gay,
lesbian, bisexual, and transgender (GLBT) pediatric patients.

RESOLVED, That our AMA-MSS amend 315.005MSS as follows:
Promoting Inclusive Gender, Sex, and Sexual Orientation
Options on Medical Documentation
AMA-MSS will ask (1) that our AMA 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; and (2) that our AMA advocate for
collection of patient data that is inclusive of sexual
orientation/gender identity for the purposes of research into patient
health.

RESOLVED, That our AMA-MSS amend 530.025MSS as follows:
Sexual Orientation and Gender Identity Demographic
Collection by the AMA and Other Medical Organizations
Our AMA-MSS will ask that our AMA develop a plan with input from
the LGBTQ+ advisory committee to expand the demographics we
collect about our members to include both sexual orientation and
gender identity information, which will be given voluntarily by
members and handled in a confidential manner.

WIM CEQM REPORT A – COVERAGE OF PREGNANCY-ASSOCIATED HEALTHCARE FOR
12 MONTHS POSTPARTUM FOR UNINSURE D PATIENTS WHO ARE INELIGIBLE FOR
MEDICAID

MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

Your Women in Medicine Committee and Committee on Economics and Quality in Medicine
recommend that the following resolve clauses be adopted in lieu of Resolution 049 and the
remainder of this report be filed:

RESOLVED, That our AMA amend policy D-290.974, Extending Medicaid Coverage for One
Year Postpartum, by addition as follows:
D-290.974 – EXTENDING MEDICAID COVERAGE FOR PREGNANCY AND ONE YEAR POSTPARTUM
1. Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum; and
2. Our AMA will work with relevant stakeholders to expand Medicaid eligibility for pregnant and postpartum non-citizen immigrants.

RESOLVED, That our AMA amend policy H-165.828, Health Insurance Affordability, by addition as follows:

H-165.828 – HEALTH INSURANCE AFFORDABILITY
1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee’s premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA’s “family glitch,” thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the “family glitch,” and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.

WIM REPORT A – SUPPORT FOR FAMILY PLANNING FOR MEDICAL STUDENTS
MSS ACTION: ADOPT AS AMENDED AND FILE REPORT

Your Women in Medicine Committee recommends that the following resolve clauses be adopted in lieu of Resolution 51-I-19 and the remainder of this report be filed:

RESOLVED, That our AMA-MSS amend policy 295.207MSS as follows:

295.207MSS – FAMILY PLANNING FOR MEDICAL STUDENTS
AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including, parental maternity and paternity leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and (2) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood; and (3) supports medical schools providing 6 weeks of parental leave for medical students of all genders, medical school or broader licensure-related policies that allow for students to take a full six week leave without delaying graduation, and (4) encourages medical schools to make these formal policies easily accessible for both current and prospective students.

; and be it further

RESOLVED, That our AMA-MSS continue to support family leave related policies brought forth by other delegations so as not to diminish incremental advancement in advocacy related to this topic.
SUMMARY OF ACTIONS

JUNE 2021 SPECIAL MEETING OF THE HOUSE OF DELEGATES
VIRTUAL

MSS-AUTHORED RESOLUTIONS

*WILL BE UPDATED FOLLOWING JUNE 2021 SPECIAL MEETING OF THE HOUSE OF DELEGATES*

RESOLUTION 015 – OPPOSITION TO THE CRIMINALIZATION AND UNDUE RESTRICTIONS OF EVIDENCE-BASED GENDER-AFFIRMING CARE FOR TRANSGENDER AND GENDER DIVERSE INDIVIDUALS

HOD ACTION:
RESOLVED, XXX

RESOLUTION 123 – MEDICARE ELIGIBILITY AT AGE 60

HOD ACTION:
RESOLVED, XXX

RESOLUTION 215 – EXEMPTIONS TO WORK REQUIREMENTS AND ELIGIBILITY EXPANSIONS IN PUBLIC ASSISTANCE PROGRAMS

HOD ACTION:
RESOLVED, XXX

RESOLUTION 216 – OPPOSITION TO FEDERAL BAN OF SNAP BENEFITS FOR PERSONS CONVICTED OF DRUG-RELATED FELONIES

HOD ACTION:
RESOLVED, XXX

RESOLUTION 217 – AMENDING H-150.962, QUALITY OF SCHOOL LUNCH PROGRAM, TO ADVOCATE FOR THE EXPANSION AND SUSTAINABILITY OF NUTRITIONAL ASSISTANCE PROGRAMS DURING COVID-19

HOD ACTION:
RESOLVED, XXX

RESOLUTION 218 – ADVOCATING FOR ALTERNATIVES TO IMMIGRANT DETENTION CENTERS THAT RESPECT HUMAN DIGNITY

HOD ACTION:
RESOLVED, XXX

RESOLUTION 219 – OPPOSE TRACKING OF PEOPLE WHO PURCHASE NALOXONE

HOD ACTION:

RESOLVED, XXX

RESOLUTION 229 – CLASSIFICATION AND SURVEILLANCE OF MATERNAL MORTALITY

HOD ACTION:

RESOLVED, XXX

RESOLUTION 230 – CONSIDERATIONS FOR IMMUNITY CREDENTIALS DURING PANDEMICS AND EPIDEMICS

HOD ACTION:

RESOLVED, XXX

RESOLUTION 314 – STANDARD PROCEDURE FOR ACCOMMODATIONS IN USMLE AND NBME EXAMS

HOD ACTION:

RESOLVED, XXX

RESOLUTION 413 – CALL FOR INCREASED FUNDING AND RESEARCH FOR POST-VIRAL SYNDROMES

HOD ACTION:

RESOLVED, XXX

RESOLUTION 414 – CALL FOR IMPROVED PPE DESIGN AND FITTING

HOD ACTION:

RESOLVED, XXX

RESOLUTION 415 – AMENDING H-440.847, TO CALL FOR NATIONAL GOVERNMENT AND STATES TO MAINTAIN PPE AND MEDICAL SUPPLY STOCKPILES

HOD ACTION:

RESOLVED, XXX

RESOLUTION 417 – AMENDMENT TO FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD
HOD ACTION:
RESOLVED, XXX

RESOLUTION 421 – MEDICAL MISINFORMATION IN THE AGE OF SOCIAL MEDIA
HOD ACTION:
RESOLVED, XXX

RESOLUTION 610 – PROMOTING EQUITY IN GLOBAL VACCINE DISTRIBUTION
HOD ACTION:
RESOLVED, XXX