Abridged Handbook Document is currently laid out for letter-sized paper; change as desired.

Note: this table includes only the recommendations from reports and the resolve statements from resolutions. The table can be sorted in Word using either the “committee” column or the “item” column (or both). Alternatively, the table can be copied to a spreadsheet and manipulated there. The table includes all items of business excepting informational reports. Only the primary sponsor, usually the submitter, is listed for resolutions.

| **Cmte\*** | **Item** | **Sponsor†** | **Title** | **Recommendations or Resolves** |
| --- | --- | --- | --- | --- |
| F | BOT 01 | n/a | Annual Report | The Consolidated Financial Statements for the years ended December 31, 2022 and 2021 and the Independent Auditor’s report have been included in a separate booklet, titled “2022 Annual Report.” This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing. |
| .CON | BOT 02 | n/a | New Specialty Organizations Representation in the House of Delegates | Therefore, the Board of Trustees recommend that the American Academy of Addiction Psychiatry, American Society for Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action) |
| F | BOT 04 | n/a | AMA 2024 Dues | The Board of Trustees recommends no change to the dues levels for 2024, that the following be adopted and that the remainder of this report be filed:  Regular Members - $420  Physicians in Their Fourth Year of Practice - $315  Physicians in Their Third year of Practice - $210  Physicians in Their Second Year of Practice - $105  Physicians in Their First Year of Practice - $60  Physicians in Military Service - $280  Semi-Retired Physicians - $210  Fully Retired Physicians - $84  Physicians in Residency/Fellow Training - $45  Medical Students - $20 |
| B | BOT 09 | n/a | Council on Legislation Sunset Review of 2013 House Policies | The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. |
| B | BOT 11 | n/a | HPSA and MUA Designation For SNFs | The Board of Trustees recommends that the following policies be reaffirmed in lieu of Resolution 224-A-22, and the remainder of the report be filed:  1. That our AMA reaffirm Policy H-465.981, which asks our AMA to:  a. support legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status;  b. encourage federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements;  c. explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result;  d. supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders; and  e. undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities. (Reaffirm HOD Policy)  2. That our AMA reaffirm Policy H-200.972, “Primary Care Physicians in Underserved Areas”, which provides a plan for the AMA to improve the recruitment and retention of physicians in underserved areas with underserved populations. (Reaffirm HOD Policy)  3. That our AMA reaffirm Policy H-280.979, which asks our AMA to support the following:  a. continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;  b. continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;  c. efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and  d. assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting.  (Reaffirm HOD Policy)  4. That our AMA reaffirm Policy D-200.980, which asks our AMA to advocate for the following:  a. Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations;  b. Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program;  c. Adequate funding for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas; and  d. Encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.  (Reaffirm HOD Policy)  5. That our AMA reaffirm Policy H-200.954, which encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations. (Reaffirm HOD Policy)  6. That our AMA reaffirm Policy H-465.988, which provides educational strategies for meeting rural health physician shortages. (Reaffirm HOD Policy) |
| B | BOT 12 | n/a | Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners | The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 248-A-22 and that the remainder of the report be filed.  1. That our American Medical Association (AMA) reaffirm existing Policy H-35.965, “Regulation of Physician Assistants,” and H-35.989, “Physician Assistants.” (Reaffirm HOD Policy)  2. That Policy H-360.987, “Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice” be amended by addition and deletion as follows:  (5) ~~Physicians should encourage~~ Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards ~~explore the feasibility of working together to coordinate their regulatory initiatives and activities~~. (Modify Current HOD Policy) |
| F | BOT 13 | n/a | Delegate Apportionment and Pending Members | Therefore, your Board of Trustees recommends that paragraphs 2-4 of Policy G-600.016 and paragraph 1 of Policy G‑600.959 be rescinded and the remainder of the report filed. |
| G | BOT 14 | n/a | Advocacy of Private Practice Options for Healthcare Operations in Large Corporations | The Board of Trustees recommends that the following be adopted and the remainder of the report be filed:  1. That our American Medical Association (AMA) reaffirm the following policies:  a. D-405.988, “The Preservation of the Private Practice of Medicine”  b. H-385.904, “Prospective Payment Model Best Practices for Independent Private Practice”  c. H-185.939, “Value-Based Insurance Design”  d. D-140.951, “Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices”  e. H-160.891, “Corporate Investors”; (Reaffirm HOD Policy) and  2. That our AMA will: (1) inform corporate efforts about the value of private practices to successfully participate in new “value-based” models; (2) identify and work with a corporate entity that is advancing these models to explore a two year pilot among independent private practices in which the AMA will: (a) convene physician practices in a community; (b) provide educational resources and technical assistance to practices to support their participation with the corporate entity and (c) formally evaluate the pilot for outcomes; and (3) advocate with commercial payers and health plans and federal and state payers and policymakers to support private practice through policies and models that provide adequate payment, infrastructure and data to succeed in “value-based” models. (Directive to Take Action)  3. That Policy D-160.912 be rescinded as having been accomplished by this report. (Rescind HOD Policy) |
| .CON | BOT 15 | n/a | National Cancer Research Patient Identifier | In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of Resolution 021, A-22, “National Cancer Research Patient Identifier,” and the remainder of this report be filed:  Our AMA encourages greater use of code and data sharing to enhance the timely conduct of research in oncology and implementation of innovations in care. |
| D | BOT 17 | n/a | AMA Public Health Strategy | The Board of Trustees recommends that the following be adopted in lieu of Resolution 605-A-22 and the remainder of the report be filed.  1. Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA’s efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. |
| F | BOT 18 | n/a | Making AMA Meetings Accessible | The Board of Trustees recommends that Policy G-630.140 [8] be rescinded as being accomplished by this report, and the remainder of the report be filed. |
| F | BOT 20 | n/a | Surveillance Management System for Organized Medicine Policies and Reports | In view of these considerations, your AMA recommends that the following recommendations be adopted in lieu of Resolution 609-A-22 and that the remainder of this report be filed:  1. That our American Medical Association (AMA) maintains the existing resolution management structure within the House of Delegates without imposing a potentially confusing or unsustainable prioritization matrix on delegates and reference committees. (New HOD Policy)  2. That our AMA continues to invest in critical information technology and other appropriate infrastructure that allows for the tracking of past resolutions, existing policy, and supporting materials. (New HOD Policy) |
| .Con | CCB 01 |  | AMA Bylaws--Gender Neutral Language and Miscellaneous Update | The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting. |
| F | CCB/CLRPD 01 |  | Joint Council Sunset Review of 2013 House Policies | The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. |
| .Con | CEJA 01 |  | Utilization Review, Medical Necessity Determination, Prior Authorization Decisions | Based on the foregoing considerations, the Council on Ethical and Judicial Affairs recommends that paragraph 2 of D-320.977, “Utilization Review, Medical Necessity Determination, Prior Authorization Decisions,” be rescinded as having been accomplished and the remainder of this report be filed:  1. Our AMA will advocate: (a) for implementation of a federal version of a prior authorization “gold card” law, which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations; and (b) that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization, including a “gold-card” or “preferred provider program.”  ~~2. Our AMA will request that the Council on Ethical and Judicial Affairs review current ethical opinions similar to the Texas Medical Association Board of Councilors opinions regarding medical necessity determination and utilization review.~~ |
| .Con | CEJA 02 |  | Ethical Principles for Physicians Involved in Private Equity Owned Practices | In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, “Contracts to Deliver Health Care Services,” be amended as follows and the remainder of this report be filed:  Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other  considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services physicians consider carefully the proposed contract to assure themselves that ~~the~~ its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts do not create untenable conflicts of interests~~ do not obviously compromise their ability to fulfill their fiduciary obligations to patients.  Ongoing evolution in the health care system continues to bring changes to medicine, including  changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians’ ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians’ freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.  As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, or other entities—they should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to ~~impede~~ put patients’ interests at risk  When ~~contracting~~ partnering with other entities to provide health care services, physicians should:  (a) Carefully review the terms of proposed contracts or have a representative do so on their behalf to assure themselves that the arrangement:  (i) Minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care or other mechanisms intended to influence physicians’ treatment recommendations or direct what care patients receive, in keeping with ethics guidance.  (ii) Does not compromise physicians’ own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk.  (iii) Allows the physician to appropriately exercise professional judgment.  (iv) Includes a mechanism to address grievances and supports advocacy on behalf of individual patients.  (v) Permits disclosure to patients.  (vi) Enables physicians to participate in, if not outright control, decisions about practice staffing.  (b) Negotiate modification or removal of any terms that unduly compromise physicians’ ability to uphold ethical standards.  When physicians enter into arrangements with partners who may later sell the practice, physicians should seek explicit commitments that subsequent partners will sustain fidelity to patients and respect physicians’ professional ethical obligations. |
| .Con | CEJA 03 |  | Short-Term Medical Service Trips | In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:  Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such service trips also provide training and educational opportunities, they may offer benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.  By definition, short-term medical service trips take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for volunteers, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate host and team resources. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of participants and sponsors in collaboration with host communities.  Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:  (a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should prioritize efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team or the sponsoring organization.  (b) Seek to proactively identify and minimize burdens the trip places on the host community, including not only direct, material costs of hosting volunteers, but also possible adverse effects the presence of volunteers could have for beneficial local practices and practitioners. Sponsors and participants should ensure that team members practice only within their skill sets and experience.  (c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources that help them to cultivate the cultural sensitivity they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience. Volunteers should be clear that they may be ethically required to decline requests for treatment that cannot be provided safely and effectively due to resource constraints.  Sponsors of short-term medical service trips should:  (d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally. This includes arranging for local mentors, translation services, and volunteers’ personal health needs. It should not be assumed that host communities can absorb additional costs, even on a temporary basis.  (e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, so that they can provide safe, high-quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with professional standards they would deem acceptable for practice in their home country, even if the host country’s standards are more flexible or less rigorously enforced.  (f) Ensure appropriate supervision of trainees, consistent with their training in their home countries, and make certain that they are only permitted to practice independently in ways commensurate with their level of experience in resource-limited settings.  (g) Ensure a mechanism for meaningful data collection is in place, consistent with recognized standards for the conduct of health services research and quality improvement activities in the sponsor’s country. |
| .Con | CEJA 04 |  | Responsibilities to Promote Equitable Care | In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:  Medicine at its core is a moral activity rooted in the encounter between a patient who is ill and a physician who professes to heal. The “covenant of trust” established in that encounter binds physicians in a duty of fidelity to patients. As witness to how public policies ultimately affect the lives of sick persons, physicians’ duty of fidelity also encompasses a responsibility to recognize and address how the policies and practices of the institutions within which physicians work shape patients’ experience of health, illness, and care. As the physical and social settings of medical practice, hospitals and other health care institutions share the duty of fidelity and, with physicians, have a responsibility to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.  Enduring health disparities across patient populations challenge these duties of fidelity. Disparities reflect the habits and practices of individual clinicians and the policies and decisions of individual health care institutions, as well as deeply embedded, historically rooted socioeconomic and political dynamics. Neither individual physicians nor health care institutions can entirely resolve the problems of discrimination and inequity that underlie health disparities, but they can and must accept responsibility to be agents for change.  In their individual practice, physicians have an ethical responsibility to address barriers to equitable care that arise in their interactions with patients and staff. They should:  a) Cultivate self-awareness and strategies for change, for example, by taking advantage of training and other resources to recognize and address implicit bias;  b) Recognize and avoid using language that stigmatizes or demeans patients in face-to-face interactions and entries in the medical record;  c) Use the social history to capture information about non-medical factors that affect a patient’s health status and access to care to inform their relationships with patients and the care they provide.  Within their institutions, as professionals with unique knowledge, skill, experience, and status, physicians should collaborate with colleagues to promote change. They should:  d) Support one another in creating opportunities for critical reflection across the institution;  e) Identify institutional policies and practices that perpetuate or create barriers to equitable care;  f) Participate in designing and supporting well-considered strategies for change to ensure equitable care for all.  As institutions in and through which health care occurs, hospitals and other health care institutions share medicine’s core values and commitment of fidelity, and with it ethical responsibility to promote equitable care for all. Moreover, as entities that occupy positions of power and privilege within their communities, health care institutions are uniquely positioned to be agents for change. They should:  g) Support efforts within the institution to identify and change institutional policies and practices that may perpetuate or create barriers to equitable care;  h) Engage stakeholders to understand the histories of the communities they serve and recognize local drivers of inequities in health and health care;  i) Identify opportunities and adopt strategies to leverage their status within the community to minimize conditions of living that contribute to adverse health status. |
| .Con | CEJA 05 |  | CEJA’s Sunset Review of 2013 House Policies | The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action) |
| C | CME 01 | n/a | Council on Medical Education Sunset Review of 2013 House of Delegates’ Policies | The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action) |
| C | CME 02 | n/a | Financing Medical Education | The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 306-A-22 and the remainder of this report be filed:  1. That Policy D-305.952, “Medical Student Debt and Career Choice,” be reaffirmed. (Reaffirm HOD Policy)  2. That Policy H-305.925, “Principles of and Actions to Address Medical Education Costs and Student Debt,” be amended by addition of a new point (23), to read “(23) continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.” (Amend HOD Policy)  3. That our AMA encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels. (New HOD Policy)  4. That Policy D-305.984 (5), "Reduction in Student Loan Interest Rates,” be rescinded, as having been fulfilled by this report:  ~~"Work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training."~~ (Rescind HOD Policy) |
| C | CME 03 | n/a | Financial Burdens and Exam Fees for International Medical Graduates | The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 305-A-22, and the remainder of this report be filed:  1. That our American Medical Association (AMA) encourage key stakeholders, such as the National Board of Medical Examiners, Federation of State Medical Boards, Educational Commission for Foreign Medical Graduates (a member of Intealth), Cambridge Assessment English and Box Hill Institute, and others to (a) study the most equitable approach for achieving parity across U.S. MD and DO trainees and international medical graduates with regard to application, exam, and licensing fees and related financial burdens; and (b) share this information with the medical education and IMG communities. (Directive to Take Action)  2. That our AMA encourage relevant stakeholders to work together to achieve cost equivalency for exams required of all medical students and trainees, including IMGs. (Directive to Take Action)  3. That AMA policy H-255.988, “AMA Principles on International Medical Graduates,” be reaffirmed. (Reaffirm HOD Policy) |
| C | CME 04 | n/a | Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance | The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 309-A-22, Resolve 2, and the remainder of this report be filed:  That our American Medical Association (AMA):  1. Continue to encourage work in support of the Coalition for Physician Accountability’s Undergraduate Medical Education-Graduate Medical Education Review Committee “Recommendations for Comprehensive Improvement of the UME-GME Transition.” (Directive to Take Action)  2. Encourage and support UME institutions’ investment in a) developing more valid, reliable, and unbiased summative assessments for clinical clerkships, including development of assessors’ awareness regarding structural inequities in education and wider society, and b) providing standardized and meaningful competency data to program directors. (New HOD Policy)  3. Encourage institutions to publish information related to clinical clerkship grading systems and residency match rates, with subset data for learners from varied groups, including those that have been historically underrepresented in medicine or may be affected by bias. (New HOD Policy)  4. Encourage UME institutions to include grading system methodology with grades shared with residency programs. (New HOD Policy)  5. Reaffirm the following policies:  - D-295.307, “Decreasing Bias in Evaluations of Medical Student Performance”  - H-295.866, “Supporting Two-Interval Grading Systems for Medical Education”  - D-295.317, “Competency Based Medical Education Across the Continuum of Education and Practice”  - D-295.318, “Competency-Based Portfolio Assessment of Medical Students” |
| C | CME 05 | n/a | Support for Institutional Policies for Personal Days for Undergraduate Medical Students | The Council on Medical Education therefore recommends that the following recommendation be adopted in lieu of Resolution 314-A-22 and the remainder of this report be filed:  1. That our AMA support a requirement that each medical school have policy defining 1) the number of days a medical student may be excused from each curricular component; 2) the processes for using excused absences, providing alternative, timely means of achieving curricular goals when absent from a curricular component; and 3) effective mechanisms to communicate these policies at appropriate times throughout the curriculum; and that schools be encouraged to create a mechanism by which at least some portion of such days can be used without requiring explanation. (New HOD Policy) |
| C | CME 06 | n/a | Modifying Financial Assistance Eligibility Criteria for Medical School Applicants | The Council on Medical Education therefore recommends that the following recommendations be adopted, and the remainder of this report be filed:  1. That AMA policy [D-305.950](https://policysearch.ama-assn.org/policyfinder/detail/D-305.950?uri=%2FAMADoc%2Fdirectives.xml-D-305.950.xml), Modifying Financial Assistance Eligibility Criteria for Medical School Applicants, be amended by addition and deletion to read as follows:  1. Our AMA will ~~work with~~ encourage the Association of American Medical Colleges~~,~~ and American Association of Colleges of Osteopathic Medicine~~, and other appropriate stakeholders~~ to study process reforms ~~that could help~~ to mitigate the high cost of applying to medical school ~~for low-income applicants, including better targeting application fee waivers through broadened eligibility criteria,~~ and ensure cost parity among applicants to DO and MD granting institutions.  2. Our AMA will encourage the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and U.S. Department of Education to reevaluate application forms to financial aid programs such as the Fee Assistance Program (FAP), Fee Waiver Program (FWP), and Free Application for Federal Aid (FASFA) to broaden eligibility criteria for low-income students.  3. Our AMA will commend the U.S. Department of Education for removing references to parental/guardian income for all medical students in the Free Application for Federal Aid (FASFA).  4. Our AMA will encourage the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine as well as medical school and state-based financial aid programs to remove references to parental/guardian income for all medical students and follow the U.S. Department of Education’s definition of “independent student” as described in the Free Application for Federal Aid (FASFA). (Modify Current HOD Policy) |
| C | CME 07 | n/a | Management and Leadership Training in Medical Education | The Council on Medical Education therefore recommends that the following recommendations be adopted, and the remainder of this report be filed:  1. That clause (1) of AMA policy D-295.316 be rescinded as such directives have been accomplished per the actions, programs, and resources summarized in this report.  ~~1. “Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.”~~ (Rescind HOD Policy)  2. That clauses (2) and (3) of AMA policy D-295.316 be amended by addition and deletion to read as follows:  2. “Our AMA supports ~~will work with key stakeholders to advocate for~~ collaborative programs among medical schools, residency programs, and related schools of business and management to ~~better~~ give physicians the opportunity to assume ~~for~~ administrative, financial, and leadership responsibilities in medical management.”  3. “Our AMA: (a) ~~will advocate for and~~ supports and participates in the creation and promotion of management and leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills, and management techniques integral to achieving ~~personal and professional~~ financial literacy and leading interprofessional ~~team~~ health care teams~~, in the spirit of the AMA's Accelerating Change in Medical Education initiative~~; and (b) encourages ~~will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other to~~ the organizations ~~governing bodies~~ responsible for the education of future physicians to implement programs ~~early in~~ throughout medical training to ~~promote the~~ develop~~ment of~~ management and leadership competencies and ~~personal and professional~~ financial literacy capabilities.” (Modify Current HOD Policy)  3. That AMA policy D-295.316 be amended by addition of new clause (3c) to read as follows:  Our AMA: (c) encourages key stakeholders to collect and analyze data on the effectiveness of management and leadership training and share such information with the medical education community. (Directive to Take Action)  4. That clause (4a) of AMA policy D-295.316 be rescinded, as having been accomplished by the writing of this report.  Our AMA will: ~~(a) study the extent of the impact of AMA Policy D-295.316, “Management and Leadership for Physicians,” on elective curriculum; and (b)~~ expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health. (Rescind HOD Policy)  5. That AMA policy D-295.316 be amended by addition of a new clause (5), to read as follows:  Our AMA will create a central online directory of its management and leadership resources that is searchable on the AMA website and promote the directory and these resources to AMA members and the medical education community. |
| C | CME 08 | n/a | Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict | The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:  1. That American Medical Association (AMA) Policy D-275.989, “Credentialing Issues,” be amended as follows:  Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept ~~the Educational Commission for Foreign Medical Graduates~~ certification by the Educational Commission for Foreign Medical Graduates (a member of Intealth) as proof of primary source verification of an IMG’s international medical education credentials. (Modify Current HOD Policy)  2. That AMA Policy D-255.975, “Hardship for International Medical Graduates from Russia and Belarus,” be rescinded, as having been fulfilled by this report:  ~~“Our AMA will study the impact of the current political crisis on international medical graduates with medical degrees from Russia and Belarus who are already in the U.S. either in training or practicing in regards to their ability to obtain primary source verification and report back during the 2022 Interim House of Delegates meeting.”~~ (Rescind HOD Policy) |
| C | CME 09 | n/a | The Impact of Midlevel Providers on Medical Education | The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 201-A-22 and the remainder of the report be filed:  1. That the American Medical Association (AMA) encourage appropriate medical education accreditation organizations in allopathic and osteopathic medicine including the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to:  A) Incorporate the phrase “physician-led” as a modifier for “interprofessional education” into their relevant medical education accreditation standards, where appropriate;  B) Require education in and evaluation of competency in physician-led interprofessional health care team leadership as part of the systems-based practice competency in medical education accreditation standards. (New HOD Policy)  2. That the AMA encourage medical educators to study how interprofessional learning and teamwork promote the development of physician leadership in team-based care. (New HOD Policy)  3. Amend D-295.934 (2) by addition as follows: “Our AMA supports the concept that medical education should prepare students for practice in, and leadership of, physician-led interprofessional health care teams.” (New HOD Policy)  4. That the AMA encourage medical standards-setting organizations, including the American Board of Medical Specialties and its member boards, to inform policymakers of the standards physicians are held to for independent practice in order to protect patients and that these standards make physicians the appropriate leaders of the interprofessional health care team. (Modify Current HOD Policy) |
| G | CMS 01 |  | Council on Medical Service Sunset Review of 2013 House Policies | The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. |
| A | CMS 02 |  | Medicare Coverage of Dental, Vision, and Hearing Services | 1. That our American Medical Association (AMA) support physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings. (New HOD Policy)  2. That our AMA encourage the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia. (New HOD Policy)  3. That our AMA amend Policy H-25.990 by addition to read as follows:  Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. (Amend HOD Policy)  4. That our AMA reaffirm Policy D-160.925, which recognizes the importance of managing oral health and the importance of dental care to optimal patient care and supports the exploration of opportunities for collaboration with the American Dental Association (ADA) on comprehensive strategy for improving oral health care and education for clinicians. (Reaffirm HOD Policy)  5. That our AMA reaffirm Policy H-330.872, which supports the American Medical Association’s continued work with the ADA to improve access to dental care for Medicare beneficiaries and supports initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (Reaffirm HOD Policy)  6. That our AMA reaffirm Policy H-185.929, which supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare’s benefit and policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly and supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (Reaffirm HOD Policy)  7. That our AMA reaffirm Policy D-390.946, which supports the American Medical Association’s work towards the elimination of budget neutrality requirements within Medicare Part B. (Reaffirm HOD Policy) |
| A | CMS 03 |  | Private Insurer Payment Integrity | 1. That our American Medical Association (AMA) support the development of a comprehensive, evidence-based process to establish consistency in determinations of experimental/investigational status and transparency in coverage determinations from which insurers can develop benefit packages. (New HOD Policy)  2. That our AMA support voluntary programs that expedite review for coverage by private and governmental insurers when requested by either the manufacturer or third parties such as national medical specialty societies. (New HOD Policy)  3. That our AMA amend Policy D-185.986 by the addition of one new clause, as follows:  Our AMA will advocate that when clinical coverage protocols are more restrictive than governmental payers, that private insurers and benefit managers should include the clinical rationale substantiating their coverage policies. (Modify Current HOD Policy)  4. That our AMA reaffirm Policy H-185.964, which opposes new health benefit mandates unrelated to patient protections.(Reaffirm HOD Policy)  5. That our AMA reaffirm Policy H-165.856, which advocates for the minimization of benefit mandates. (Reaffirm HOD Policy)  6. That our AMA reaffirm Policy H-320.995, which urges payers to share third party methodologies for determining “medical necessity,” and advocates for the opportunity for treating physicians to provide medical evidence toward those determinations. (Reaffirm HOD Policy)  7. That our AMA reaffirm Policy D-460.967, which calls for study of the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models to increase access to investigational therapies. (Reaffirm HOD Policy) |
| A | CMS 04 |  | Bundled Payments and Medically Necessary Care | 1. That our American Medical Association (AMA) amend Policy H-390.849[2, 3] by addition and deletion to read as follows:  2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.  3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, ~~verifiable, accurate, and based on current data~~ reliable, and consistent with national medical specialty society-developed clinical guidelines/standards. (Modify HOD Policy)  2. That our AMA amend Policy D-385.952[1, 2] by addition and deletion to read as follows:  Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations, ~~and~~ reductions in health care disparities, and functional improvements, if appropriate; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations and safeguard patient access to medically necessary care, including institutional post-acute care. (Modify HOD Policy)  3. That our AMA reaffirm Policy H-385.907, which supports risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors; risk adjustment systems that use fair and accurate outlier payments if spending on a patient exceeds a pre-defined threshold, and fair and accurate payments for external price changes beyond the physician’s control; and accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence. (Reaffirm HOD Policy)  4. That our AMA reaffirm Policy H-385.913, which outlines goals for physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, limit physician accountability to aspects of spending and quality that they can reasonably influence, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue working with national medical specialty societies and state medical associations to educate physicians on APMs. (Reaffirm HOD Policy) |
| G | CMS 05 |  | Prescription Drug Dispensing Policies | 1. That our American Medical Association (AMA) support the development and implementation of clear guidelines and mechanisms to indicate that the quantity of a prescription should be dispensed only as written using such language as “dispense quantity as written” or “no change in quantity.” (New HOD Policy)  2. That our AMA amend Policy H-185.942, to read as follows:  1. Our AMA supports the protection of the patient-physician relationship from interference by payers and Pharmacy Benefit Managers (PBMs) via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.  2. Our AMA will work with third party payers and PBMs to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.  3. Our AMA supports interested state legislative efforts and federal action and will develop model state legislation to ensure that third party payers or PBMs that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following…. (Amend AMA Policy)  3. That our AMA reaffirm Policy H-320.953, which defines the term “medical necessity” as referenced in the suggested amended policy H-185.942 (above) in recommendation two. (Reaffirm AMA Policy)  4. That our AMA reaffirm Policy H-120.952, which ensures that the quantity of a medication dispensed to patients is of adequate supply, not overregulated, and that receiving the medication is not an undue burden on the patient or the prescribing physician. (Reaffirm HOD Policy)  5. That our AMA reaffirm Policy D-120.934, which ensures that prescriptions must be filled as ordered, including the quantity, and that PBMs and payers restrict policies that impact patient access to prescription medications. (Reaffirm HOD Policy) |
| A | CMS 07 |  | Reporting Multiple Services Performed During a Single Patient Encounter | 1. That our American Medical Association (AMA) support mechanisms to report modifiers appropriately with the least administrative burden possible, including the development of electronic health record tools to facilitate the reporting of multiple, medically necessary services supported by modifier 25. (New HOD Policy)  2. That our AMA support comprehensive education for physicians and insurers on the appropriate use of modifier 25. (New HOD Policy)  3. That our AMA reaffirm Policy D-70.971, which advocates for the acceptance of Current Procedural Technology (CPT®) modifiers, particularly modifier 25, and the appropriate alteration of payment based on CPT modifiers. (Reaffirm HOD Policy)  4. That our AMA reaffirm Policy D-385.956, which directs the AMA to aggressively and immediately advocate through any legal means possible to ensure that when an evaluation and management (E/M) code is reported with modifier 25, that both the procedure and E/M codes are paid at the non-reduced, allowable payment rate. (Reaffirm HOD Policy)  5. That our AMA reaffirm Policy H-385.944, which supports insurance company payment for E/M services and procedures performed on the same day. (Reaffirm HOD Policy)  6. That our AMA reaffirm Policy D-70.959, which advocates that a CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure. (Reaffirm HOD Policy) |
| G | CMS 08 |  | Impact of Integration and Consolidation on Patients and Physicians | 1. That our American Medical Association (AMA) continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor. (New HOD Policy)  2. That our AMA continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians. (New HOD Policy)  3. That our AMA broadly support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions that may fall below the Federal Trade Commission(FTC)/Department of Justice review threshold. (New HOD Policy)  4. That our AMA encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior. (New HOD Policy)  5. That our AMA encourage physicians to share their experiences with mergers and acquisitions, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form. (New HOD Policy)  6. That our AMA rescind policy D-215.984. (Rescind HOD Policy) |
| G | CMS 09 |  | Federally Qualified Health Centers and Rural Health Care | 1. That our American Medical Association (AMA) support certification requirements and other policies that reduce the administrative burden for physicians practicing in Federally Qualified Health Center (FQHCs). (New HOD Policy)  2. That our AMA support sufficient federal funding to maintain the operation and costs associated with establishing and operating a FQHC, FQHC “Look-Alike”, or Outpatient Tribal Facility. (New HOD Policy)  3. That our AMA reaffirm Policy H-465.994, which supports efforts to develop and implement proposals and programs to improve the health of rural communities. (Reaffirm HOD Policy)  4. That our AMA reaffirm Policy D-390.923, which advocates for the authorization of Chronic Care Management reimbursement for all physicians, including those practicing in FQHCs or Rural Health Clinics. (Reaffirm HOD Policy)  5. That our AMA reaffirm Policies H-160.947 and H-35.965, which both advocate for the support of state and local medical societies in identifying and working to prevent laws that may allow for non-physicians (e.g., nurse practitioners, physician assistants) to operate without the supervision of a physician. (Reaffirm HOD Policy) |
| F | Comp Report | n/a | Compensation Committee Report | 1. That there be no changes to the Officers’ compensation for the period beginning July 1, 2023 through June 30, 2024. (Directive to Take Action.)  2. That the remainder of the report be filed. |
| E | CSAPH 01 |  | Oppose Scheduling of Gabapentin | The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed.  1. That Policy D-120.927, “Oppose Scheduling of Gabapentin” be amended by addition and deletion to read as follows with recognition that several aspects of this directive have been accomplished:  Our AMA will:  1. actively oppose the placement of (a) gabapentin ~~(2-[1-(aminomethyl) cyclohexyl] acetic acid)~~, including its salts, and all products containing gabapentin ~~(including the brand name products Gralise and Neurontin)~~ and (b) gabapentin enacarbil ~~(1-{[({(1RS)-1-[(2- methylpropanoyl)oxy]ethoxy} carbonyl)amino]methyl} cyclohexyl) acetic acid)~~, including its salts, ~~(including the brand name product Horizant)~~ into schedule V or other restricted class of the Controlled Substances Act;  ~~2. submit a timely letter to the Commissioner of Food and Drug for the proceedings assigned docket number FDA-2022-P-0149 in opposition to placement of gabapentin and gabapentin enacarbil into the schedule V of the Controlled Substance Act; and~~  ~~3. study the off-label use and potential risks and benefits of gabapentin to the general population as well as to those individuals with substance use disorders.~~  2. affirm that given currently available data, the FDA and DEA have used the appropriate process for evaluating the safety, efficacy, and risk of misuse and dependency for gabapentin and its salts;  3. support the promotion of gabapentin-related research and education, particularly the risk of gabapentinoids when taken concomitantly with opioids, including in current clinical practice and undergraduate, graduate and post-graduate education. (Modify Current AMA Policy)  2. That our AMA reaffirm Policies H-120.988, “Patient Access to Treatments Prescribed by Their Physicians”, H-120.922, “Improved Access and Coverage to Non-Opioid Modalities to Address Pain”, and H-95.922, “Substance Use and Substance Use Disorders.” (Reaffirm Current AMA Policy) |
| E | CSAPH 02 |  | Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices | The Council on Science and Public Health recommends the following be adopted, and the remainder of the report be filed:  1. Our AMA believes that to support innovation while protecting patient safety, approval pathways for medical devices should incorporate the following principles:  a. Evidence-based, measurable performance benchmarks, such as those used in the Safety and Performance Based Pathway, should be used wherever possible for classes of known, well-studied medical devices; and  b. For a subset of higher risk devices receiving approval but have not completed clinical trials, time-limited approvals may be appropriate, after which the manufacturer may be required to provide post-market data to support full device approval; and  c. Medical devices with known safety concerns should not be usable as predicate devices for the purposes of proving substantial equivalence. In the event safety concerns of predicate devices arise after approval has been granted, additional due diligence should be initiated as appropriate; and  d. Approval for medical devices should include criteria for adequate performance in racialized, minoritized, or otherwise historically excluded groups; and  e. Reports of adverse events for medical devices should always be available in a publicly accessible, searchable database such as the Manufacturer and User Facility Device Experience. (New HOD Policy)  2. That Policy H-120.988, “Patient Access to Treatments Prescribed by Their Physicians”, supporting a physician’s right to prescribe medical devices off-label, be reaffirmed. (Reaffirm Current HOD Policy) |
| E | CSAPH 03 |  | Regulation and Control of Self-Service Labs | The Council on Science and Public Health recommends the following recommendations be adopted, and the remainder of the report be filed:  1. Direct access testing, in which patients may order a diagnostic laboratory test on demand, should only be provided by teams which are physician-led, and performed in facilities that are CLIA-certified.  2. Health care professionals who offer direct access testing services, for which a patient does not have a referral, recognize that agreeing to perform direct-to-consumer testing on request:  a. establishes a patient relationship, with all the ethical and professional obligations such relationship entails; and  b. assumes responsibility for relevant clinical evaluation, including pre- and post-test counseling about the test, its results, and indicated follow-up. Health care professionals may choose to refer the patient for post-test counseling to an appropriate provider who accepts the patient, but they maintain ethical and professional responsibility until the patient has been seen by that provider; and  shall report all required findings to relevant oversight entities, such as state public health agencies, even if the patient and the laboratory are not co-localized in the same jurisdiction. (New HOD Policy)  3. That Policy H-480.941, “Direct-to-Consumer Laboratory Testing,” calling for regulation of direct-to-consumer testing and education of patients of risks and benefits, be reaffirmed. (Reaffirmation of Current AMA Policy) |
| D | CSAPH 04 |  | School Resource Officer Violence De-escalation Training and Certification | The Council on Science and Public Health recommends that the following be adopted, and the  remainder of the report be filed.  1. That our AMA amend Policy H-60.902, “School Resource Officer Qualifications and Training” as follows:  1. Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child and adolescent psychology and development, trauma-informed care, restorative justice, peer mediation, conflict resolution, crime awareness, implicit/explicit biases, how to work with children with disabilities and special needs, diversity inclusion, cultural ~~humility~~ competence of the distinct cultural groups represented at schools, de-escalation training, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors. (Modify HOD Policy)  2. That our AMA encourage: (1) school districts initiating SROs develop and those with existing SROs maintain an up-to-date Memorandum of Understanding (MOU) that clearly outlines processes for officer selection and assessment, defines roles and responsibilities of SROs and their scope relative to school personnel, identifies data to be collected, and establishes a mechanism for program evaluation and oversight; (2) SROs to have access to local public health resources; (3) schools with SRO programs to collect and report data to help evaluate the impact of SROs in schools; and (4) federal and state grant programs which provide funding for SRO programs, require collection and reporting of data to inform policymaking on these programs. (New HOD Policy)  3. That our AMA acknowledges: (1) SROs are part of the school staff at large and their responsibilities should be defined within the team; and (2) community-based policing practices are essential for a successful SRO program. (New HOD Policy) |
| D | CSAPH 05 |  | Increasing Public Umbilical Cord Blood Donation in Transplant Centers | 1. That our AMA amend Policy H-370.956 “Increasing Public Umbilical Cord Blood-Donations in Transplant Centers” as follows:  1. Our AMA encourages: (1) the availability of altruistic cord blood donations in all states; ~~and~~ (2) access to public cord banking and the creation of public cord blood banks to support altruistic cord blood donation~~.~~; (3) all hospitals that provide obstetrics services work to provide access to public (altruistic) umbilical cord blood donation; (4) that when available, to reduce barriers through education of patients about altruistic umbilical cord donation; and (5) that hospitals providing obstetrics services and umbilical cord blood banking facilities work together to create networks to expand access to and increase efficiency of altruistic umbilical cord donations.  2. Our AMA supports federal funding efforts to increase knowledge sharing across banks and mentoring for centers, physicians, and staff with minimal experience in cord blood collection.  3. AMA advocates for increased federal and state funding for public UCB banks to create networks to expand access to and increase efficiency of altruistic umbilical cord donations in areas lacking the appropriate infrastructure to effectively collect umbilical cord blood donations.  4. Our AMA supports efforts to educate physicians about best practices in collecting public umbilical cord blood donations.  5. Our AMA encourages efforts to increase the diversity of the national inventory of umbilical cord blood through funding that supports banks to add collection sites where more racial and ethnic minority cord blood units can be collected. (Modify Current HOD Policy) |
| D | CSAPH 06 |  | Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections | The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.  1. That our AMA amend policy D-430.993, “Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections” to read as follows:  ~~1. Our AMA will study best practices for interactions between hospitals, other acute care facilities, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody of such law enforcement or correctional agencies (including patients without decision-making capacity), their surrogates, and the clinicians caring for them are provided the autonomy and privacy protections afforded to them by law and in concordance with professional ethical standards and report its findings to the AMA House of Delegates by the 2023 Annual Meeting.~~  1. Our AMA supports the development of: (1) best practices for acute care of patients in the custody of law enforcement or corrections, (2) clearly defined and consistently implemented processes between health care professionals and law enforcement that (a) can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and (b) ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life/palliative, and substance use care, especially in emergency situations, and (3) a hospital or health system-based health care professional and law enforcement liaison team, that includes, but is not limited to, clinicians, members of the ethics committee, hospital security, and legal services to serve as an immediate resource when questions or conflicts arise. (Amend Current HOD Policy)  2. That our AMA affirms that: (1) the adoption of best practices in the acute care of patients in the custody of law enforcement or corrections is an important effort in achieving overall health equity for the U.S. as a whole, and (2) it is the responsibility of the medical staff to ensure quality and safe delivery of care for incarcerated patients. (New HOD Policy)  3. That our AMA reaffirm Policy D-430.997 “Support for Health Care Services to Incarcerated Persons” and Policy H-420.957 “Shackling of Pregnant Women in Labor.” (Reaffirm HOD Policy) |
| D | CSAPH 07 |  | Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders and Indications for Metabolic and Bariatric Surgery | 1. Our AMA recognizes:  1. the issues with using body mass index (BMI) as a measurement because: (a) of the eugenics behind the history of BMI, (b) of the use of BMI for racist exclusion, and (c) BMI cutoffs are based on the imagined ideal Caucasian and does not consider a person’s gender or ethnicity.  2. the significant limitations associated with the widespread use of BMI in clinical settings and suggests its use be in a conjunction with other valid measures of risk such as, but not limited to, measurements of: (a) visceral fat, (b) body adiposity index, (c) body composition, (d) relative fat mass, (e) waist circumference and (f) genetic/metabolic factors.  3. that BMI is significantly correlated with the amount of fat mass in the general population but loses predictability when applied on the individual level.  4. that relative body shape and composition heterogeneity across race/ethnic groups, sexes, and age-span is essential to consider when applying BMI as a measure of adiposity.  5. that in some diagnostic circumstances, the use of BMI should not be used as a sole criterion for appropriate insurance reimbursement. (New HOD Policy)  2. Our AMA supports further research on the application of the extended BMI percentiles and z-scores and its association with other anthropometric measurements, risk factors, and health outcomes. (New HOD Policy)  3. Our AMA supports efforts to educate physicians on the issues with BMI and alternative measures for diagnosing obesity. (New HOD Policy)  4. That our AMA amend policy H-440.866, “The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity,” to read as follows:  The Clinical Utility of Measuring Body Mass Index, Body Composition, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity, H-440.866  Our AMA supports:(1) greater emphasis in physician educational programs on the risk differences ~~among ethnic and age~~ within and between demographic groups at varying levels of adiposity, BMI, body composition, and waist circumference and the importance of monitoring these ~~waist circumference~~ in all individuals ~~with BMIs below 35 kg/m2~~; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks. (Modify Current HOD Policy).  5. That our AMA amend policy H-150.965, “Eating Disorders” to read as follows: The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one’s physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize ~~unhealthy~~ abnormal eating behaviors, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for evidence-based and culturally-informed interventional counseling; and (4) participates in this effort by consulting with appropriate, culturally-informed educational and counseling materials pertaining to ~~unhealthy~~ abnormal eating behaviors, dieting, and weight restrictive behaviors. (Modify Current HOD Policy)  6. That our AMA not adopt Resolution 937-I-22, “Indications for Metabolic and Bariatric Surgery.” |
| D | CSAPH 08 |  | Council on Science and Public Health Sunset Review of 2013 House Policies | The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action) |
| .Con | Res. 001 | Medical Student Section | Opposing Mandated Reporting of LGBTQ+ Status | RESOLVED, That our American Medical Association amend Policy H-65.959, “Opposing Mandated Reporting of People Who Question Their Gender Identity” by addition to read as follows:  Opposing Mandated Reporting of People Who Question Their Gender Identity, H-65.959  Our AMA opposes mandated reporting of individuals who identify as part of the LGBTQ+ community and those who question or express interest in exploring their gender identity and/or sexual orientation. (Modify Current Policy) |
| .Con | Res. 002 | Medical Student Section | Exclusion of Race and Ethnicity in the First Sentence of Case Reports | RESOLVED, That our American Medical Association encourage curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation (New HOD Policy); and be it further  RESOLVED, That our AMA encourage the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation. (New HOD Policy) |
| .Con | Res. 003 | Medical Student Section | Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation | RESOLVED, That our American Medical Association support initiatives that decrease financial and institutional barriers for organ transplantation to uninsured or insurance-ineligible recipients, regardless of immigration status, excluding medical tourism as defined in the AMA Code of Ethics 1.2.13 (New HOD Policy); and be it further  RESOLVED, That our AMA Council on Ethical and Judicial Affairs reconsider its Guidelines for Organ Transplantation from Deceased Donors to consider the concerns of differential access based upon immigration status (Directive to Take Action); and be it further  RESOLVED, That our AMA amend H-370.982 by addition to read as follows:  Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982  Our AMA has adopted the following guidelines as policy:  (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, immigration status, perceived obstacles to treatment or follow-up, patient contribution to illness, or past use of resources should not be considered.  (2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria  relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.  (3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.  (4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.  (5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.  (6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.  (7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means. (Modify Current HOD Policy) |
| .Con | Res. 004 | Medical Student Section | Amending Policy H-525.988, “Sex and Gender Differences in Medical Research” | RESOLVED, That our American Medical Association facilitate the inclusion of women and sexual and gender minority participants in clinical research studies and reporting of how the sex and gender of these participants influenced study outcomes requires the cooperation of researchers, federal agencies, and journal editors, by amending Policy H-525.988, “Sex and Gender Differences in Medical Research,” by addition and deletion to read as follows:  Sex and Gender Differences in Medical Research, H-525.988  Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;  (2) affirms the need to include ~~both~~ all genders in studies that involve the health of society at large and publicize its policies;  (3) supports increased funding into areas of women's health and sexual and gender minority health research;  (4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; ~~and~~  (5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative~~.~~;  (6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities; and  (7) encourages the FDA to internally develop criteria for identifying medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities. (Modify Current HOD Policy) |
| .Con | Res. 005 | Medical Student Section | Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees | RESOLVED, That our American Medical Association support the provision of safe, culturally and religiously sensitive operating room scrubs and hospital attire options for both patients and employees. (New HOD Policy) |
| .Con | Res. 006 | American Academy of Child and Adolescent Psychiatry | Ensuring Privacy as Large Retail Settings Enter Healthcare | RESOLVED, That our American Medical Association study privacy protections and the potential for data breaches of healthcare records in large retail settings. (Directive to Take Action) |
| .Con | Res. 007 | New England | Independent Medical Evaluation | RESOLVED, That our American Medical Association study and report back at the 2024 Annual Meeting on the Independent Medical Evaluation (IME) process and recommend standards and safeguards to protect injured and disabled patients. (Directive to Take Action) |
| .Con | Res. 008 | American Society of Addiction Medicine | Study on the Criminalization of the Practice of Medicine | RESOLVED, That our American Medical Association study the rapidly changing environment in which the practice of medicine has been criminalized, the degree to which such criminalization is based or not based upon valid scientific findings, as well as the degree to which this is altering the actual practice of medicine due to physician concerns and personal risk assessments, reporting back to the HOD no later than the June, 2024 Annual Meeting. (Directive to Take Action) |
| .Con | Res. 009 | Minnesota | Racism - A Threat to Public Health | RESOLVED, That our American Medical Association advocate for the creation of an International Classification of Diseases (ICD) code for patients presenting with conditions related to experiencing racism, a code that will provide physicians with the tools necessary to address racism within the clinical encounter, and capture the data needed to provide more effective patient care. (Directive to Take Action) |
| .Con | Res. 010 | Women Physicians Section | Advocating for Increased Support to Physicians in Family Planning and Fertility | RESOLVED, That our American Medical Association advocate for academic and employed physician practices to contract with insurance providers who provide infertility coverage that defrays the steep costs for fertility treatments (Directive to Take Action); and be it further  RESOLVED, That our AMA work with other key stakeholders to encourage full support of physicians desiring to have families to allow for flexible work policies and clinical coverage for those undergoing fertility treatments. (Directive to Take Action) |
| .Con | Res. 011 | Eppes, Delegate | Rights of the Developing Baby | RESOLVED, That our American Medical Association’s Council of Judicial and Ethical Affairs (CEJA) address the rights of the viable fetus in a report to be delivered no later than the 2024 Annual meeting. (Directive to Take Action) |
| .Con | Res. 012 | Eppes, Delegate | Viability of the Newborn | RESOLVED, That our American Medical Association advocate for availability of the highest standard of neonatal care to aborted fetus born alive at a gestational age of viability. (Directive to Take Action) |
| .Con | Res. 013 | Illinois | Serial (Repeated) Sperm Donors | RESOLVED, That our American Medical Association work with other relevant national medical specialty societies to study the further elaboration of potential risks associated with allowing sperm from a single donor to be used to conceive children by multiple recipients and make recommendations for additional policies to minimize these risks. (Directive to Take Action) |
| .Con | Res. 014 | Minority Affairs Section | Redressing the Harms of Misusing Race in Medicine | RESOLVED, That our American Medical Association recognize the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field (New HOD Policy); and be it further  RESOLVED, That our AMA will revise the *AMA Guides to the Evaluation of Permanent Impairment*, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine (Directive to Take Action); and be it further  RESOLVED, That our AMA support and promote racism-conscious, reparative, community-engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine. (New HOD Policy) |
| .Con | Res. 015 | New York | Report Regarding the Criminalization of Providing Medical Care | RESOLVED, That our American Medical Association study the rapidly changing environment in which the practice of medicine has been criminalized, the degree to which such criminalization is based or not based upon valid scientific findings, as well as the degree to which this is altering the actual practice of medicine due to physician concerns and personal risk assessments, reporting back to the House of Delegates no later than the 2024 Annual meeting. (Directive to Take Action) |
| A | Res. 101 | Young Physicians Section | Updating Physician Job Description for Disability Insurance | RESOLVED, That our American Medical Association study the most effective approach to developing specialty-specific job descriptions that reflect the true physical and cognitive demands of each given specialty for use in the Occupational Information System under development by the Social Security Administration so as to ensure that physician disability policies are robust and protective if a coverage trigger occurs. (Directive to Take Action) |
| A | Res. 102 | Medical Student Section | Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use | RESOLVED, That our American Medical Association encourage the Centers for Medicare and Medicaid Services (CMS) to: (a) identify groups of Physician-Administered Drugs (PADs), each comprised of the reference biologic and its biosimilars (based on FDA approvals), to be reimbursed at the same rate to incentivize selection of less expensive PADs while preserving access for patients and reimbursement for physicians; and (b) determine the method rate by which a group of PADs will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to creating fixed add-on fees to be used for all PADs in a group and indexing rate increases for a group of PADs to the rate of inflation. (New HOD Policy) |
| A | Res. 103 | Medical Student Section | Movement Away from Employer-Sponsored Health Insurance | RESOLVED, That our American Medical Association recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality healthcare (New HOD Policy); and be it further  RESOLVED, That our AMA support movement toward a healthcare system that does not rely on employer-sponsored health insurance and enables universal access to high quality healthcare (New HOD Policy); and be it further  RESOLVED, That our AMA amend Policy H-165.828, “Health Insurance Affordability”, by addition and deletion to read as follows:  HEALTH INSURANCE AFFORDABILITY, H-165.828  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).~~Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.  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. (Modify Current HOD Policy) and be it further  RESOLVED, That our AMA amend Policy H-165.823, “Options to Maximize Coverage under the AMA Proposal for Reform”, by deletion to read as follows:  OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM, H-165.823  1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.  2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:  a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.  ~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.~~  b~~c~~. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.  c~~d~~. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.  d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.  e~~f~~. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.  f~~g~~. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.  3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:  a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.  b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.  c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.  d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.  e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.  f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.  g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.  h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.  4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (Modify Current HOD Policy) |
| A | Res. 104 | Medical Student Section | Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment | RESOLVED, That our American Medical Association support that Medicare Part B cover wheelchair ramps and associated home installation for beneficiaries for whom using a wheelchair at home is "medically necessary.” (New HOD Policy) |
| A | Res. 105 | Medical Student Section | Studying Population-Based Payment Policy Disparities | RESOLVED, That our American Medical Association study opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas (Directive to Take Action); and be it further  RESOLVED, That our AMA study the effects of factors such as valuation and reimbursement rates on physician choice of specialty, degree of institutional support, workforce shortages, burnout, and attrition, especially in specialties and practice settings that primarily care for underserved populations. (Directive to Take Action) |
| A | Res. 106 | Medical Student Section | Billing for Traditional Healing Services | RESOLVED, That our American Medical Association study the impact of Medicaid waivers for managed care demonstration projects regarding implementation and reimbursement for traditional American Indian and Alaska Native healing practices provided in concert with physician-led healthcare teams. (Directive to Take Action) |
| A | Res. 107 | Medical Student Section | Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use | RESOLVED, That our American Medical Association encourage the Centers for Medicare and Medicaid Services to adjust the pricing of limited data sets in order to increase access for academic use. (New HOD Policy) |
| A | Res. 108 | District of Columbia | Sustainable Reimbursement for Community Practices | RESOLVED, That our American Medical Association study small medical practices to assess the prevalence of insurance payments to these practices that are below Medicare rates and to assess the effects of these payment levels on practices’ ability to provide care, and report back by the 2024 Annual Meeting (Directive to Take Action); and be it further  RESOLVED, That our AMA study and report back on remedies for such reimbursement rates for physician practices (Directive to Take Action); and be it further  RESOLVED, That our Council on Medical Service study the impact on small and medium-sized physician practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements (Directive to Take Action); and be it further  RESOLVED, That our AMA study and report back to the HOD options for model legislation for states and municipalities seeking to correct reimbursement rates for medical practices that are below those required to meet fixed costs. (Directive to Take Action) |
| A | Res. 109 | American Academy of Pediatrics | Improved Access to Care For Patients in Custody of Protective Services | RESOLVED, That our American Medical Association study and report back mechanisms to improve payment for physician services provided to patients under protective services custody. (Directive to Take Action) |
| A | Res. 110 | Mississippi | Long-Term Care Coverage for Dementia Patients | RESOLVED, That our American Medical Association work with Centers for Medicare & Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance plans to cover this ever-growing disenfranchised population. (Directive to Take Action) |
| A | Res. 111 | American Academy of Dermatology | Potential Negative Consequences of Accountable Care Organizations (ACOs) | RESOLVED, That our American Medical Association advocate for the provision of health care and reimbursement models that are in the best interest of patients and offer risk adjustment methodologies to prevent financial penalty to the physician and other healthcare team members who provide care for the sickest patients (Directive to Take Action); and be it further  RESOLVED, That our AMA oppose capitation care healthcare systems, such as ACOs, when such systems place physicians and other healthcare team members at financial risk for the overall healthcare costs of their patients, including costs attributable to care provided by other entities (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for flexible pathways for small practice participation in ACOs that greatly mitigate ACO participation-related bureaucratic burdens and help protect small practices from large financial penalties otherwise assigned to large health systems for cost overages (Directive to Take Action); and be it further  RESOLVED, That our AMA oppose CMS mandates that require Medicare beneficiaries to enroll in ACOs (New HOD Policy); and be it further  RESOLVED, That our AMA oppose the expansion of capitation care systems, such as ACOs, as a means of providing coverage and services for all Medicare enrollees. (New HOD Policy) |
| A | Res. 112 | American College of Chest Physicians | Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs | RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services (CMS) to encourage and insist that all states, both Medicaid expansion and traditional Medicaid, remove barriers to care for lung cancer screening, including but not limited to pre-authorization and co-pay requirements (Directive to Take Action); and be it further  RESOLVED, That our AMA, and their state medical associations, work with the Centers for Medicare & Medicaid Services (CMS) and State Medicaid Managed Care Organizations to develop and implement strategies to improve access to LDCT screening for high-risk populations in Medicaid programs (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for increased funding for research and education to further increase awareness and uptake of LDCT screening for lung cancer among high-risk populations (Directive to Take Action); and be it further  RESOLVED, That our AMA urge state medical associations to work with their respective Medicaid programs to ensure that these programs comply with the AMA's policy on LDCT screening for high-risk populations. (Directive to Take Action) |
| A | Res. 113 | Georgia | Cost of Insulin | RESOLVED, That our American Medical Association urge Congress to mandate complete coverage of any insulin approved by the FDA (at $0 cost) for any patient, insured or uninsured, who presents to the pharmacy and bypassing all PBMs and disallowing any rebates. (Directive to Take Action) |
| A | Res. 114 | Illinois | Physician and Trainee Literacy of Healthcare Costs | RESOLVED, That our American Medical Association endorse price transparency within all sectors of the healthcare market (New HOD Policy); and be it further  RESOLVED, That our AMA encourage all physician employers, including hospitals, to allow their healthcare professionals access to accurate and easily understandable costs of any laboratory test, procedure, medication, medical supply, or any other cost related to medical care within and outside their organization (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for all physician employers, including hospitals, to empower their healthcare professionals to incorporate discussions on healthcare costs during patient counseling (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for medical education inclusive of price transparency, financial literacy, and the economics and financing of healthcare delivery (Directive to Take Action); and be it further  RESOLVED, That our AMA work with the Commission of Osteopathic College Accreditation (COCA), the Liaison Committee on Medical Education (LCME), the Accreditation Council on Graduate Medical Education (ACGME), and other relevant stakeholders, to include price transparency and healthcare financing in medical education as components of program accreditation (Directive to Take Action); and be it further  RESOLVED, That our AMA study the issues around price transparency, including the feasibility of providing accurate and easily understandable costs of tests, procedures, medications, and other costs related to medical care. (Directive to Take Action) |
| A | Res. 115 | Illinois | Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer | RESOLVED, That our American Medical Association urge all payers to consider that wigs, cold caps, and medically necessary cranial prosthetics may have significant benefits to improve the quality of life for patients with cancer (New HOD Policy); and be it further  RESOLVED, That our AMA work with relevant stakeholders such as the Centers for Medicare and Medicaid Services to encourage payers to cover costs associated with wigs, cold caps, and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatments (Directive to Take Action); and be it further  RESOLVED, That our AMA work with all relevant medical specialty societies, third party payers, including The Centers for Medicare & Medicaid Services (CMS), and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for wigs, cold caps, and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatment. (Directive to Take Action) |
| A | Res. 116 | New York | Medicare Coverage of OTC Nicotine Replacement Therapy | RESOLVED, That our American Medical Association advocate for over the counter (OTC) nicotine replacement therapies, excluding vaping products, to be carved out from the non-coverage by Medicare of OTC products and be specifically covered when prescribed by physicians who care for patients with Medicare, Medicare Part D, or Medicare Part C coverage. (Directive to Take Action) |
| B | Res. 201 | American Association of Clinical Urologists | Pharmacists Prescribing for Urinary Tract Infections | RESOLVED, That our American Medical Association collaborate with relevant stakeholders including state and specialty societies to oppose legislation or regulation allowing pharmacists to test, diagnose, and treat urinary tract infections (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that inappropriate treatment of urinary tract infections with antibiotics is a public health concern which can lead to further bacterial antibiotic resistance. (Directive to Take Action) |
| B | Res. 202 | Medical Student Section | Support for Mental Health Courts | RESOLVED, That American Medical Association Policy H-100.955, Support for Drug Courts, be amended by addition and deletion as follows:  Support for Mental Health ~~Drug~~ Courts, H-100.955  Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with mental illness involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy) |
| B | Res. 203 | Medical Student Section | Drug Policy Reform | RESOLVED, That our American Medical Association advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug-related felonies (Directive to Take Action); and be it further  RESOLVED, That our AMA support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individual (New HOD Policy); and be it further  RESOLVED, That our AMA support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession. (New HOD Policy) |
| B | Res. 204 | Medical Student Section | Supporting Harm Reduction | RESOLVED, That our American Medical Association advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic (Directive to Take Action); and be it further  RESOLVED, That our AMA support any efforts to decriminalize the possession of non-prescribed buprenorphine (New HOD Policy); and be it further  RESOLVED, That our AMA amend Policy D-95.987 by addition and deletion to read as follows:  Prevention of Drug-Related Overdose, D-95.987  1. Our AMA: (a) recognizes the great burden that 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; (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 AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.  3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.  4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing, safer smoking, and injection drug preparation, use, and disposal supplies.  5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.  6. Our AMA will advocate for ~~supports efforts to~~ increased access to and decriminalization of fentanyl test strips, ~~and~~ other drug checking supplies, and safer smoking kits for purposes of harm reduction. (Modify Current HOD Policy) |
| B | Res. 205 | Medical Student Section | Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness | RESOLVED, That our American Medical Association recognize and support the use of Street Medicine programs by amending policy H-160.903 Eradicating Homelessness by addition and deletion to read as follows:  Eradicating Homelessness, H-160.903 Our AMA:  (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;  (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;  (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;  (4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;  (5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;  (6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;  (7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;  (8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;  (9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;  (10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and  (11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;  (12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals~~.~~;  (13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement~~.~~; and  (14) supports federal and state efforts to enact just cause eviction  statutes and examine and restructure punitive eviction practices;  instate inflation-based rent control; guarantee tenants’ right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries. (Modify Current HOD Policy) |
| B | Res. 206 | Medical Student Section | Tribal Public Health Authority | RESOLVED, That our American Medical Association advocate to achieve enactment of reforms to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers’ status as public health authorities (Directive to Take Action); and be it further  RESOLVED, That our AMA make a suggestion to the Department of Health and Human Services to develop sub-agency (e.g, CDC, IHS) guidance on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers (New HOD Policy); and be it further  RESOLVED, That our AMA encourage the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers. (New HOD Policy) |
| B | Res. 207 | Medical Student Section | Ground Ambulance Services and Surprise Billing | RESOLVED, That our American Medical Association oppose surprise billing practices for ground ambulance services. (New HOD Policy) |
| B | Res. 208 | Medical Student Section | Medicaid Managed Care for Indian Health Care Providers | RESOLVED, That our American Medical Association urge stronger federal enforcement of Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state Medicaid agencies and their Medicaid managed care organizations (MCO) are complying with their legal obligations to Indian health care providers (New HOD Policy); and be it further  RESOLVED, That our AMA collaborate with other stakeholders to encourage state Medicaid agencies to follow the Center for Medicare and Medicaid Services Tribal Technical Advisory Group’s recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers by, including, but not limited to:  1. Convening Tribal Advisory Committees or hiring Tribal liaisons within state Medicaid agencies.  2. Increasing the utilization of the Center for Medicare and Medicaid Services Indian Managed Care Addendum.  3. Offering employee onboarding and annual refresher training regarding Indian Health Care Medicaid Managed Care Provisions. (Directive to Take Action) |
| B | Res. 209 | Medical Student Section | Purchased and Referred Care Expansion | RESOLVED, That our American Medical Association advocate to Congress to 1) increase funding to the Indian Health Service Purchased/Referred Care Program to enable the program to fully meet the healthcare needs of AI/AN patients and 2) expand eligibility to patients served by Urban Indian Health Programs (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage nonprofit hospitals to allocate community benefit dollars to increase access to specialty care for patients referred from Indian Health Service, Tribal, and Urban Indian Health Programs. (New HOD Policy) |
| B | Res. 210 | Medical Student Section | The Health Care Related Effects of Recent Changes to the US Mexico Border | RESOLVED, That our American Medical Association recognize the health-related effects and humanitarian consequences of increasing the U.S. Mexico border barrier height on immigrant populations and the resulting effects on the U.S. healthcare system (New HOD Policy); and be it further  RESOLVED, That our AMA oppose efforts to increase the height or length of border walls and fences at the US-Mexico border, and other policies that deter people from crossing the border by increasing or creating risks to their health and safety. (New HOD Policy) |
| B | Res. 211 | Medical Student Section | Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-cost Rape Test Kits | RESOLVED, That our American Medical Association amend Policy H-80.999, “Sexual Assault Survivors,” by addition to read as follows:  Sexual Assault Survivors, H-80.999  1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.  2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.  3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.  4. Our AMA will (a) advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations; (b) support and advocate that appropriate stakeholders, such as the Health Resources and Services Administration, the United States Government Accountability Office, and the Office on Violence Against Women, create and implement a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.  5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of “backlogged” sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits. (Modify Current HOD Policy) |
| B | Res. 212 | Oklahoma | Marijuana Product Safety | RESOLVED, That our American Medical Association support the policy against marijuana use, either medical or recreational, until such time scientifically valid and well-controlled clinical trials are done to assess the safety and effectiveness as any new drug for medical use, prescription or nonprescription (New HOD Policy); and be it further  RESOLVED, That our AMA Council on Legislation draft state model legislation for states that have legalized “medical” or “recreational” marijuana that (1) prohibit dispensaries from selling marijuana products if they make any misleading health information and/or therapeutic claims, (2) to require dispensaries to include a hazardous warning on all marijuana product labels similar to tobacco and alcohol warnings and (3) ban the advertising of marijuana dispensaries and marijuana products in places that children frequent. (Directive to Take Action) |
| B | Res. 213 | Senior Physicians Section | Telemedicine Services and Health Equity | RESOLVED, That our American Medical Association advocate for preservation of the physician telemedicine waiver and reimbursement at parity with in-person visits beyond December 31, 2024 (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage research to determine the scope and circumstances of telehealth improved health outcomes, especially for underserved populations and seniors with complex health conditions that includes how best to ensure patients have the training in the use of technology needed to maximize its benefits. (New HOD Policy) |
| B | Res. 214 | Senior Physicians Section | Advocacy and Action for a Sustainable Medical Care System | RESOLVED, That our American Medical Association continue to strongly advocate for fair reimbursement of all segments of health care, particularly physicians, to undo inadequate payment relative to inflation (Directive to Take Action); and be it further  RESOLVED, That our AMA seek ongoing reimbursement adjustments for fair physician payment at least on an annual basis in order to match that given to hospitals, extended and ambulatory care facilities, medical device and pharmaceutical companies for rising practice costs and inflation. (Directive to Take Action) |
| B | Res. 215 | Medical Student Section | Supporting Legislative and Regulatory Efforts Against Fertility Fraud | RESOLVED, That our American Medical Association oppose physicians using their own sperm to artificially inseminate patients without proper explicit and informed patient consent, otherwise known as illicit insemination or fertility fraud (New HOD Policy); and be it further  RESOLVED, That our AMA support legislative and regulatory efforts to protect patients from physicians and healthcare practitioners who inseminate their own sperm into patients without their consent. (New HOD Policy) |
| B | Res. 216 | American Academy of Pediatrics | Improved Foster Care Services for Children | RESOLVED, That our American Medical Association encourage and support state, territory, and tribe activities to implement changes to the child welfare system directed toward safely keeping children with their families when appropriate (New HOD Policy); and be it further  RESOLVED, That our AMA support federal and state efforts to expand access to evidence -based services which can prevent foster care and keep families safely together, including mental health, substance use disorder treatment, and in-home parent skills-based services (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage and support state efforts expanding use of kinship and family foster care placement and state efforts to eliminate the use of non-therapeutic congregate foster care placement (New HOD Policy); and be it further  RESOLVED, That our AMA support both federal and state funding for improvements to the child welfare system which minimize harm to the child and help provide additional services to families that will safely prevent child separation from the family (New HOD Policy); and be it further  RESOLVED, That our AMA urge the development and promotion of a continuously updated and comprehensive list of evaluated and tested prevention services and programs for families at risk for entry into the child welfare system. (New HOD Policy) |
| B | Res. 217 | American Academy of Child and Adolescent Psychiatry | Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools | RESOLVED, That our American Medical Association encourage states, including communities and school districts therein, to adopt legislative and regulatory policies that allow schools to make naloxone readily accessible to school staff, teachers, and students to prevent opioid overdose deaths on school campuses (New HOD Policy); and be it further  RESOLVED, That our AMA encourage states, including communities and school districts therein, to eliminate barriers that preclude students from carrying naloxone in school. (New HOD Policy) |
| B | Res. 218 | Mississippi | Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners | RESOLVED, That our American Medical Association, in accordance with Centers for Medicare & Medicaid Services (CMS) Regulations and standards of practice for emergency medicine as defined by American College of Emergency Physicians and American Association of Emergency Medicine, advocate for the enforcement of CMS regulations and the adoption of standards set by national organizations of emergency medicine physicians, and hold accountable hospital systems, staffing organizations, medical staff groups, and individual physicians supporting systems of care that promote direct supervision of emergency departments by nurse practitioners. (Directive to Take Action) |
| B | Res. 219 | Mississippi | Repealing the Ban on Physician-Owned Hospitals | RESOLVED, That our American Medical Association advocate for policies that alleviate any restriction upon physicians from owning, constructing, and/or expanding any hospital facility type - in the name of patient safety, fiscal responsibility, transparency, and in acknowledgment of physicians dedication to patient care (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for the implementation of safeguards and regulations to ensure that physician-owned hospitals are operating in the best interests of patients (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage further study and research into the benefits and drawbacks of physician-owned hospitals and their impact on patient care, as well as the potential impact of regulatory safeguards to ensure transparency and accountability in physician-owned hospitals (New HOD Policy); and be it further  RESOLVED, That our AMA work with policymakers to develop regulations that promote transparency and accountability in physician-owned hospitals, and protect against any potential conflicts of interest, while also fostering competition and innovation in the healthcare market (Directive to Take Action); and be it further  RESOLVED, That our AMA continue to support physician leadership in healthcare and advocate for policies that enable physicians to provide the highest quality care to their patients, including policies that remove unnecessary barriers to physician ownership of hospitals (Directive to Take Action); and be it further  RESOLVED, That our AMA work to educate its members and the public on the potential benefits of physician ownership of hospitals and the need for policies that support such ownership (Directive to Take Action); and be it further  RESOLVED, That our AMA collaborate with other stakeholders, including hospital associations, patient advocacy groups, and government agencies, to develop and promote policies that support physician ownership of hospitals (Directive to Take Action); and be it further  RESOLVED, That our AMA direct the appropriate stakeholders to report back to the AMA on the progress made in implementing these resolutions, with recommendations for future action as appropriate. (Directive to Take Action) |
| B | Res. 220 | New England | Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations | RESOLVED, That our American Medical Association advocate that the Centers for Medicare and Medicaid Services require that Medicare Advantage Organizations (MAOs) pay for routine costs for services that are provided as part of clinical trials covered under the Clinical Trials National Coverage Determination 310.1, just as the MAO would have been required to do so had the patient not enrolled in the qualified clinical trial. (Directive to Take Action) |
| B | Res. 221 | Pennsylvania | In Support for Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool | RESOLVED, That our American Medical Association amend AMA Policy D-95.987, “Prevention of Drug-Related Overdose,” by addition to read as follows:  1. Our AMA: (a) recognizes the great burden that 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; (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 AMA will: advocate for the removal of FTS from the legal definition of drug paraphernalia.  3. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.  4. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.  5. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.  6. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.  7. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction by supporting both legalization of FTS use by patients, as well as training in FTS use, by pertinent professionals. (Modify Current HOD Policy) |
| B | Res. 222 | Pennsylvania | Physician Ownership of Hospital Blocked by the ACA | RESOLVED, That our American Medical Association explore and report back to the House of Delegates at the 2024 Annual Meeting, the feasibility of filing judicial or legislative challenges to the ban on physician ownership of new hospitals under the relevant provisions of the Affordable Care Act. (Directive to Take Action) |
| B | Res. 223 | The Endocrine Society | Protecting Access to Gender Affirming Care | RESOLVED, That our American Medical Association work with state and specialty societies and other interested organizations to oppose any and all criminal and other legal penalties against patients seeking gender-affirming care and against parents and guardians who support minors seeking and receiving gender-affirming care; including the penalties of loss of custody and the inappropriate characterization of gender-affirming care as child abuse (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for protections from violence, criminal or other legal penalties, adverse medical licensing actions, and liability, including responsibility for future medical costs, for (a) healthcare facilities that provide gender-affirming care; (b) physicians and other healthcare providers who provide gender-affirming care; and (c) patients seeking and receiving gender-affirming care (Directive to Take Action); and be it further  RESOLVED, That our AMA work with state and specialty societies and other interested organizations to advocate against state and federal legislation that would prohibit or limit gender-affirming care (Directive to Take Action); and be it further  RESOLVED, That our AMA work with other interested organizations to communicate with the Federation of State Medical Boards about the importance of preserving gender-affirming care despite government intrusions (Directive to Take Action); and be it further  RESOLVED, That our AMA amend policy H-185.927, “Clarification of Medical Necessity for Treatment of Gender Dysphoria,” by insertion and deletion as follows:  Clarification of Medical Necessity for Treatment of Gender Dysphoria, H-185.927  Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoriaand gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoriaand gender incongruence; and (3) ~~opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care~~ will support legislation, ballot initiatives and state and federal policies to protect access to gender affirming care. (Modify Current HOD Policy) |
| B | Res. 224 | American Society for Metabolic and Bariatric Surgery | Advocacy Against Obesity-Related Bias by Insurance Providers | RESOLVED, That our American Medical Association urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to  1. Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.  2. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient’s medical provider  3. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.  4. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes (Directive to Take Action); and be it further  RESOLVED, That the AMA support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. (Directive to Take Action) |
| B | Res. 225 | American Thoracic Society | Regulation of “Cool/Non-Menthol” Tobacco Products | RESOLVED, That our American Medical Association advocate that tobacco products that use additives that create a “cooling effect” should be treated as a tobacco product with a characterizing flavor for legal and regulatory purposes. (Directive to Take Action) |
| B | Res. 226 | Michigan | Vision Qualifications for Driver’s License | RESOLVED, That our American Medical Association engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on standardized vision requirements for unrestricted and restricted driver’s licensing privileges. (Directive to Take Action) |
| B | Res. 227 | Michigan | Reimbursement for Postpartum Depression Prevention | RESOLVED, That our American Medical Association amend Policy H-420.95, “Improving Mental Health Services for Pregnant and Postpartum Mothers,” by addition and deletion to read as follows:  Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953  Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; ~~and~~ (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs; and (5) will advocate for evidence-based postpartum depression prevention services to be recognized as the standard of care for all federally-funded health care programs for pregnant women. (Modify Current HOD Policy) |
| B | Res. 228 | Michigan | Reducing Stigma for Treatment of Substance Use Disorder | RESOLVED, That our American Medical Association support and advocate for coverage for transportation costs for all Medicaid or Medicare health care services without a “carve out” for patients diagnosed with a substance use disorder who are being treated with medication for opioid use disorder. (Directive to Take Action) |
| B | Res. 229 | Michigan | Firearm Regulation for Persons Charged with or Convicted of a Violent Offense | RESOLVED, That our American Medical Association study the effect of including a rescindment period of 10 years for the possession of a firearm by persons convicted of a violent offense in accordance with other established rescindment periods adopted by other states. (Directive to Take Action) |
| B | Res. 230 | Michigan | Address Disproportionate Sentencing for Drug Offenses | RESOLVED, That our American Medical Association actively lobby for federal and state legislation aimed at eliminating the national crack and powder cocaine sentencing disparity (from 18:1 to 1:1) and apply it retroactively to those already convicted or sentenced (Directive to Take Action); and be it further  RESOLVED, That our AMA collaborate with appropriate stakeholders, including, but not limited to, courts, government agencies, professional organizations, and criminal/social justice organizations to advocate for addressing excessive legal punishments for low-level, nonviolent drug crimes at state and federal levels. (Directive to Take Action) |
| B | Res. 231 | Michigan | Equitable Interpreter Services and Fair Reimbursement | RESOLVED, That our American Medical Association support the standardization of physician reimbursement in regard to interpreter services, whether it be through the usage of a Current Procedural Terminology (CPT) code or direct reimbursement by payers including Medicaid programs and Medicaid managed care plans (New HOD Policy); and be it further  RESOLVED, That our AMA reaffirm Policy D-385.957, “Certified Translation and Interpreter Services,” which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services and relieve the burden of the costs associated with translation services. (Reaffirm HOD Policy) |
| B | Res. 232 | Minnesota | Supervised Injection Facilities (SIFs) Allowed by Federal Law | RESOLVED, That our American Medical Association amend policy H-95.925, “Pilot Implementation of Supervised Injection Facilities,” by addition to read as follows:  Pilot Implementation of Supervised Injection Facilities H-95.925  “Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use, including supporting changes to federal law to permit the operation of pilot SIFs in the United States. Until federal law permits the operation of pilot SIFs in the United States, our AMA will regularly pursue explicit commitments from each active presidential administration that federal lawsuits will not be filed against operators of pilot SIFs. (Modify Current HOD Policy) |
| B | Res. 233 | Missouri | Dobbs – EMTALA Medical Emergency | RESOLVED, That our American Medical Association advocate for policies to ensure that all patients receive prompt, complete and unbiased emergency health care that is medically sound and evidence-based, in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA). (Directive to Take Action) |
| B | Res. 234 | American Academy of Dermatology | Medicare Physician Fee Schedule Updates and Grassroots Campaign | RESOLVED, That our American Medical Association’s top priority be to advocate for positive annual updates to the Medicare Physician Fee Schedule (PFS) to accurately account for annual inflation, cost of living, and practice expense increases (Directive to Take Action); and be it further  RESOLVED, That our AMA actively engage in an AMA-organized and sponsored national grassroots campaign that educates patients about how lack of sufficient positive updates to the physician fee schedule places physician practice survivability and access to quality health care at risk (Directive to Take Action); and be it further  RESOLVED, That this newly-created AMA grassroots campaign actively engage America's patients, as constituents, to use their influence to lobby Congress in favor of positive Medicare PFS updates to help ensure the survivability of physician practices and access to quality health care for all. (Directive to Take Action) |
| B | Res. 235 | American College of Emergency Physicians | EMS as an Essential Service | RESOLVED, That our American Medical Association recognize that the provision of Emergency Medical Services is an essential service of government and is best overseen by physicians with specialized training in medical direction for Emergency Medical Services (New HOD Policy); and be it further  RESOLVED, That our AMA work with the American College of Emergency Physicians (ACEP), the National Registry of Emergency Medical Technicians (NREMT), the National Association of EMS Physicians (NAEMSP), the National Association of State EMS Officials (NASEMSO), and other relevant stakeholders to create model legislation at the state level to establish funding for Emergency Medical Services as an essential service (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for federal funding of Emergency Medical Services as an essential service. (Directive to Take Action) |
| B | Res. 236 | American College of Cardiology | AMA Support for Nutrition Research | RESOLVED, That our American Medical Association seek national legislation in support of the President’s FY24 Budgetary request that the National Institutes of Health’s (NIH’s) Office of Nutrition Research (ONR) receive at least $121,000,000, as this level of funding would enable ONR to secure the leadership, organizational structure, and resources to effectively fulfill its important mission. (Directive to Take Action) |
| B | Res. 237 | California | Prohibiting Covenants Not-To-Compete in Physician Contracts | RESOLVED, That our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers (New HOD Policy); and be it further  RESOLVED, That our AMA oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program (New HOD Policy), and be it further  RESOLVED, That our AMA study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of 1) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and 2) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination. (Directive to Take Action) |
| B | Res. 238 | Arizona | Eliminate Mandatory Medicare Budget Cuts | RESOLVED, That our American Medical Association continue to advocate for new legislation on Medicare physician payment reform. (Directive to Take Action) |
| B | Res. 239 | Arizona | Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians | RESOLVED, That our American Medical Association Board of Trustees study and report back at the 2023 Interim meeting on the economic impact to primary care and other lower tier income medical specialties of specialty switching by Advanced Practice Providers (Directive to Take Action); and be it further  RESOLVED, That our AMA Board of Trustees study and report back at the 2023 Interim meeting about possible options on how APP’s can best be obligated to stay in a specialty tract that is tied to the specialty area of their supervising physician in much the same way their supervisory physicians are tied to their own specialty, with an intent for the study to look at how the house of medicine can create functional barriers that begin to make specialty switching by Advanced Practice Providers appropriately demanding. (Directive to Take Action) |
| B | Res. 240 | Illinois | Attorneys’ Retention of Confidential Medical Records and Controlled Medical Expert’s Tax Returns After Case Adjudication | RESOLVED, That our American Medical Association advocate that attorney requests for controlled medical expert personal tax returns should be limited to 1099-MISC forms (miscellaneous income) and that entire personal tax returns (including spouse’s) should not be forced by the court to be disclosed (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate through legislative or other relevant means the proper destruction by attorneys of medical records (as suggested by Haage v. Zavala, 2021 IL 125918) and medical expert’s personal tax returns within sixty days of the close of the case. (Directive to Take Action) |
| B | Res. 241 | Illinois | Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents | RESOLVED, That our American Medical Association amend Policy H-95.945, Prescription Drug Diversion, Misuse and Addiction, to include prescription drug monitoring program (PDMP) viewing access as a mainstay of appropriate and comprehensive medical training for clinical medical students and residents. (Modify Current HOD Policy) |
| B | Res. 242 | Illinois | Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure | RESOLVED, That our American Medical Association adopt policy in support of and cause to be introduced legislation requiring any peer to peer review require a physician from the same specialty as the physician requesting a procedure for their patient, be involved in the peer to peer phone call and decision process. (New HOD Policy) |
| B | Res. 243 | Illinois | Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony | RESOLVED, That our American Medical Association advocate through legislative or other relevant means the use of the Daubert Standard to replace the Frye Standard for Expert Witness Testimony. (Directive to Take Action) |
| B | Res. 244 | American Association of Public Health Physicians | Recidivism | RESOLVED, That our American Medical Association advocate and encourage federal, state, and local legislators and officials to increase the number of community mental health facilities to meet the need of indigent, homeless, and released previously incarcerated persons (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to increase the number of community drug rehabilitation facilities to meet the needs of indigent, homeless, and released previously incarcerated persons (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to ensure there are enough residential/rehabilitation facilities for formerly incarcerated persons to live (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to ensure that correctional facilities have adequate well-trained personnel who can ensure that those incarcerated persons released from their facility are able to immediately have access to mental health, drug and residential rehabilitation facilities at an appropriate level (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and officials to advocate prompt reinstatement in governmental medical programs and insurance for those being released from incarceration facilities. (Directive to Take Action) |
| B | Res. 245 | Association for Clinical Oncology | Biosimilar/Interchangeable Terminology | RESOLVED, That our American Medical Association repeal policy H-125.976, Biosimilar Interchangeability Pathway (Rescind HOD Policy); and be it further  RESOLVED, That our AMA advocate for state and federal laws and regulations that support patient and physician choice of biosimilars and remove the “interchangeable” designation from the FDA’s regulatory framework. (Directive to Take Action) |
| B | Res. 246 | Association for Clinical Oncology | Modification of CMS Interpretation of Stark Law | RESOLVED, That our American Medical Association request that the Center for Medicare & Medicaid Services retract the determination that delivery of medicine to a patient using the Postal Service, a commercial package service, or by a trusted surrogate violates the in-office exception of the Stark Law (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for legislation to clarify that a surrogate may deliver medicine dispensed at a physician-owned pharmacy without being in violation of the Stark Law if the Center for Medicare & Medicaid Services does not change its position on disallowing the delivery of medicine to a patient using the Postal Service or a commercial package service. (Directive to Take Action) |
| B | Res. 247 | Hsu, Delegate | Assessing the Potentially Dangerous Intersection Between AI and Misinformation | RESOLVED, That our American Medical Association study the potential for AI to augment medical and public health misinformation, as well as the potential to augment cyber-libel, cyber-slander, cyber-bullying, and dissemination of internet misinformation about physicians; and that our AMA propose appropriate state and federal regulations and legislative remedies, with a report back at the 2023 Annual meeting. (Directive to Take Action) |
| B | Res. 248 | Indiana | Supervised Consumption Sites | RESOLVED, That our American Medical Association seek information and consider policy and legislation regarding the federal legalization of overdose prevention sites (Directive to Take Action); and be it further  RESOLVED, That our AMA amend policy H-95.925, Pilot Implementation of Supervised Injection Facilities, to replace the references to “supervised injection facilities” with “overdose prevention sites”. (Modify Current HOD Policy) |
| B | Res. 249 | Indiana | Restrictions on Social Media Promotion of Drugs | RESOLVED, That our American Medical Association seek policy and legislation that would limit social media’s promotion and dissemination of corporate advertisement on usage of commercial and illicit drugs to our youth. (Directive to Take Action) |
| B | Res. 250 | Indiana | Medicare Budget Neutrality | RESOLVED, That our American Medical Association reaffirm its position supporting removal of budget neutrality for Medicare physician payments, which would result in regular positive updates for physicians so that the payments can keep up with inflation and practice expenses. (New HOD Policy) |
| B | Res. 251 | Maryland | Federal Government Oversight of Augmented Intelligence | RESOLVED, That our American Medical Association study and develop recommendations on how to best protect public health by regulation and oversight of the development and implementation of augmented intelligence and its applications in the healthcare arena. (Directive to Take Action) |
| B | Res. 252 | Maryland | Strengthening Patient Privacy | RESOLVED, That our American Medical Association study the modern threats to patient privacy, especially in the context of augmented intelligence, and generate recommendations to guide AMA advocacy in this area for the betterment of patient rights. (Directive to Take Action) |
| B | Res. 253 | New York | Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination) | RESOLVED, That our American Medical Association create a policy stating that payors should compensate physicians for asynchronous (outside the day of a patient visit) non-visit or remote care, such phone calls, electronic messaging, and review of laboratory data (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for expansion of Current Procedural Terminology (CPT) codes 99441-99445 into telemedicine parity law, that will include reimbursement similar to other CPT codes. (Directive to Take Action) |
| B | Res. 254 | American College of Surgeons | Eliminating the Party Statement Exception in Quality Assurance Proceedings | RESOLVED, That our American Medical Association reaffirm the importance of meaningful Quality Assurance proceedings that are unhindered by legal discovery concerns (New HOD Policy); and be it further  RESOLVED, That our AMA strongly support and advocate for eliminating the Party Statement Exception to confidentiality at Quality Assurance meetings in all applicable laws. (Directive to Take Action) |
| B | Res. 255 | Georgia | Correctional Medicine | RESOLVED, That our American Medical Association work with interested parties and key stake holders, including the American College of Emergency Physicians, to develop model federal legislation requiring health care facilities to inform patients in custody about their rights as a patient under applicable federal and state law. (Directive to Take Action) |
| B | Res. 256 | American Society for Surgery of the Hand | Regulating Misleading AI Generated Advice to Patients | RESOLVED, That our American Medical Association commence a study of the benefits and unforeseen consequences to the medical profession of GPTs, with report back to the HOD at the 2023 interim meeting (Directive to Take Action); and be it further  RESOLVED, That our AMA consider working with the Federal Trade Commission and other appropriate organizations to protect patients from false or misleading AI-generated medical advice (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage physicians to educate our patients about the benefits and risks of consumers facing generative pretrained transformers. (New HOD Policy) |
| C | Res. 301 | Resident and Fellow Section | Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education | RESOLVED, That our American Medical Association continue to support equal treatment of osteopathic students, trainees and physicians in the residency application cycle and workplace through continued education on the training of Osteopathic physicians (New HOD Policy); and be it further  RESOLVED, That our American Medical Association encourage education on the benefits of evidence-based Osteopathic Manual Therapy for musculoskeletal conditions in medical education of allopathic students and in primary care residencies. (New HOD Policy) |
| C | Res. 302 | Resident and Fellow Section | Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and Other Relevant Associations or Organizations | RESOLVED, That our American Medical Association study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants. (Directive to Take Action) |
| C | Res. 303 | Resident and Fellow Section | Medical School Management of Unmatched Medical Students | RESOLVED, That our American Medical Association convene a task force of appropriate AMA councils, medical education organizations, licensing and credentialing boards, government bodies, impacted communities, and other relevant stakeholders to:  1. Study institutional and systemic factors associated with the unmatched medical graduate status, including, but not limited to:  a) The GME bottleneck on training positions, including the balance of entry-level position and categorical/advanced positions;  b) New medical schools and the expansion of medical school class sizes;  c) Race, geography, income, wealth, primary language, gender, religion, ability, and other structural factors;  d) Student loan debt;  e) Predatory business practices by medical schools, loan agencies, private equity, and other groups that prioritize profit over student success rates;  f) The context, history, and impact of past reports on the state of undergraduate medical education, including the Flexner Report;  g) The format and variations of institutional and medical organization guidance on best practices to successful matching;  2. Develop best practices for medical schools and medical organizations to support unmatched medical graduates, including, but not limited to:  a) Tools to identify and remediate students at high risk for not matching into GME programs;  b) Adequate data on student success rates (e.g., by specialty), and factors associated with success in matching;  c) Medical school responsibilities to unmatched medical students and graduates;  d) Outcomes-based tuition relief or reimbursement for unmatched students, wherein, unmatched students are returned some component of their tuition to ease the financial burden of being unable to practice clinical medicine;  e) Transparent, equity-based solutions to address and ameliorate any inequities identified in the match process;  f) Alternative, cost-neutral, graduate-level degrees with earlier graduation for students at high risk for not matching;  g) Career opportunities for unmatched U.S. seniors and US-IMGs; and  3. Require transparency from stakeholders, including medical schools, about any actions taken based on the report of this task force, particularly with regard to the remediation of medical students. (Directive to Take Action) |
| C | Res. 304 | Medical Student Section | Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement | RESOLVED, That our American Medical Association advocate for expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for equitable reimbursement of gender-affirming procedures by health insurance providers, including public and private insurers. (Directive to Take Action) |
| C | Res. 305 | Medical Student Section | Indian Health Service Graduate Medical Education | RESOLVED, That our American Medical Association advocate for the establishment of an Office of Academic Affiliations with the Indian Health Service (IHS) responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs (Directive to Take Action); and be it further  RESOLVED, That our AMA support the development of novel graduate medical education (GME) funding streams for full-time positions at Indian Health Service, Tribal, and Urban Indian Health Programs. (New HOD Policy) |
| C | Res. 306 | Medical Student Section | Increased Education and Access to Fertility Resources for U.S. Medical Students | RESOLVED, That our American Medical Association work with the Association of American Medical Colleges and other appropriate organizations to develop gender- and sexual minority-inclusive initiatives in medical education that raise awareness about (1) how peak child-bearing years correspond to the peak career-building years for many medical students and trainees; (2) the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees; (3) the high rate of infertility among medical students, trainees, and physicians; and (4) various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs (Directive to Take Action); and be it further  RESOLVED, That our AMA work with relevant organizations to increase access to strategies by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage. (Directive to Take Action) |
| C | Res. 307 | Medical Student Section | Amending AMA Policy H-295.858, “Access to Confidential Health Services for Medical Students and Physicians” to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents | RESOLVED, That our American Medical Association policy H-295.858, “Access to Confidential Health Services for Medical Students and Physicians,” be amended by addition and deletion to read as follows:  Access to Confidential Health Services for Medical Students and APhysicians H-295.858  1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:  A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that:  (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;  B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;  C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and  D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.  2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.  3. Our AMA encourages ~~medical schools~~ undergraduate and graduate medical programs to create mental health and substance abuse awareness and suicide prevention screening programs that would:  A. be available to all medical students, residents, and fellows on an opt-out basis  B. ensure anonymity, confidentiality, and protection from administrative action;  C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and  D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.  4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.  5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.  6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.  7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach. (Modify Current HOD Policy) |
| C | Res. 308 | Medical Student Section | Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants | RESOLVED, That our American Medical Association encourage transparency from institutions in the medical school application process for DACA recipients, including the following and on a national level when possible: (1) the percentage of Deferred Action for Childhood Arrivals applicants of total applicants, (2) the percentage of accepted Deferred Action for Childhood Arrivals applicants of total accepted applicants, (3) the percentage of matriculated Deferred Action for Childhood Arrivals students of total matriculated applicants, (4) financial aid and scholarship options available for Deferred Action for Childhood Arrivals applicants. (New HOD Policy) |
| C | Res. 309 | Medical Student Section | Against Legacy Preferences as a Factor in Medical School Admissions | RESOLVED, That our American Medical Association recognize that legacy admissions are rooted in discriminatory practices (New HOD Policy); and be it further  RESOLVED, That our AMA oppose the use of legacy status as a screening tool for medical school admissions (New HOD Policy); and be it further  RESOLVED, That our AMA study the prevalence and impact of legacy status in medical school admissions. (Directive to Take Action) |
| C | Res. 310 | Medical Student Section | Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation | RESOLVED, That our American Medical Association collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment across ACGME accredited residency programs. (Directive to Take Action) |
| C | Res. 311 | Medical Student Section | Residency Application Support for Students of Low-Income Backgrounds | RESOLVED, That our American Medical Association advocate for residency application platforms that are no-cost to all residency applicants (Directive to Take Action); and be it further  RESOLVED, That our AMA support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services. (New HOD Policy) |
| C | Res. 312 | Medical Student Section | Indian Health Service Licensing Exemptions | RESOLVED, That our American Medical Association advocate that physicians at Indian Health Service, Tribal, and Urban Indian Health Programs be exempt from duplicative licensure requirements, such as requirements for state licensure when these physicians are already federally licensed (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that future health reform proposals include corresponding licensure and eligibility exceptions for Indian Health Service, Tribal, and Urban Indian Health Program facilities and physicians to ensure that these physicians can fully participate. (Directive to Take Action) |
| C | Res. 313 | International Medical Graduates Section | Filtering International Medical Graduates During Residency or Fellowship Applications | RESOLVED, That our American Medical Association collaborate with relevant stakeholders to identify alternative methods of reducing the number of applications to review without using a discriminatory filtering system that deprives international medical graduates of equitable training opportunities (Direction to Take Action); and be it further  RESOLVED, That our AMA advocate for removal of the ability to filter out international medical graduates during application to a residency or fellowship. (Directive to Take Action) |
| C | Res. 314 | International Medical Graduates Section | Support for International Medical Graduates from Turkey | RESOLVED, That our American Medical Association publicly recognize and express its support to immigrant physicians and trainees from Turkey (New HOD Policy); and be it further  RESOLVED, That our AMA acknowledge and address interpersonal and acute systemic factors that negatively affect Turkish IMGs and their families (New HOD Policy); and be it further  RESOLVED, That our AMA affirm its support and advocate for immigrant physicians and trainees working in the United States when their country of origin faces major humanitarian crises, to promote an understanding of the challenges specific to immigrant physicians (Directive to Take Action); and be it further  RESOLVED, That our AMA support the development and implementation of channels of communication for immigrant physicians to share their personal and professional journey when facing severe destruction, humanitarian crises, or personal losses in their country of origin, contributing therefore to improving the understanding of the difficulties faced by immigrant physicians. (New HOD Policy) |
| C | Res. 315 | Michigan | Prohibit Discriminatory ERAS® Filters in NRMP Match | RESOLVED, That our American Medical Association oppose the use of discriminatory filters for foreign graduates in the Electronic Residency Application Service® (ERAS®) system and aggressively work to eliminate discriminatory filters including, but not limited to, those based on foreign medical school training, that prevent international medical graduates and others from consideration based on merit. (Directive to Take Action) |
| C | Res. 316 | Illinois | Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges | RESOLVED, That our American Medical Association amend Policy H-275.970, Licensure Confidentiality, by addition to read as follows:  1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing and/or privileging, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards these entities to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards, specialty boards, hospitals and other organizations involved in credentialing and/or privileging to exclude from license application forms and associated application forms including credentialing/privileging application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards and related organizations; and (e) encourages state licensing boards, specialty boards, hospitals and other organizations involved in credentialing and/or privileging to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.  2. Our AMA will encourage will verify that, by 2024, those state medical boards, specialty boards, hospitals, and other organizations involved in credentialing/privileging that wish to retain questions about the health of applicants on medical licensing applications use language consistent with that recommended by the Federation of State Medical Boards, which reads, “Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No).”  3. Our AMA will work with the Federation of State Medical Boards, the American Hospital Association, the American Board of Medical Specialties, and state medical societies to develop policies and strategies to ensure that by 2024 all new and renewal medical licensure and associated applications and application reference forms, privileging, credentialing and related applications and documentation will request or disclose only information that is reasonably needed to address the applicant’s current fitness to practice medicine and respect the privacy of physician’s protected health information. (Modify Current HOD Policy) |
| C | Res. 317 | Illinois | Supporting Childcare for Medical Residents | RESOLVED, That our American Medical Association reaffirm Policy D-200.974, Supporting Child Care for Health Care Professionals, committing to investigate barriers to childcare for medical trainees, as well as innovative childcare methods. (Reaffirm HOD Policy) |
| C | Res. 318 | Illinois | Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions | RESOLVED, That our American Medical Association encourage education for medical trainees in healthcare leadership, which may include additional degrees at the master’s level and/or certificate programs, in order to increase physician-led healthcare systems. (New HOD Policy) |
| C | Res. 319 | Minority Affairs Section | Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement | RESOLVED, That our American Medical Association recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts (New HOD Policy); and be it further  RESOLVED, That our AMA collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure (Directive to Take Action); and be it further  RESOLVED, That our AMA amend D-295.963, Continued Support for Diversity in Medical Education, by addition and deletion to read as follows:  Our AMA will: (1) publicly state and reaffirm its ~~stance on~~ support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), 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; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; and (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement. |
| C | Res. 320 | Minority Affairs Section | Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession | RESOLVED, That our American Medical Association amend H-350.979, Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession, by deletion and addition to read as follows:  (3) urging medical school and undergraduate admissions committees to c~~onsider minority representation as one factor in reaching their decisions~~ proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA amend D-200.985, Strategies for Enhancing Diversity in the Physician Workforce, by deletion and addition to read as follows:  (12) unequivocally opposes legislation that would ~~undermine institutions’ ability to properly employ~~ dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA recognize the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment within medical education that will propagate the advancement of health equity through diversification of the physician workforce. (New HOD Policy) |
| C | Res. 321 | New York | Corporate Compliance Consolidation | RESOLVED, That our American Medical Association work to create a minimum, standard curriculum for corporate compliance education requirements, the completion of which is acceptable to all stakeholders (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for satisfactory completion of the new approved standard corporate compliance curriculum at one setting to fulfill the requirements of all settings that require such a mandate, to eliminate wasting of valuable physician time and effort. (Directive to Take Action) |
| C | Res. 322 | New York | Disclosure of Compliance issues and Creating a National Database of Joint Leadership | RESOLVED, That our American Medical Association urge the Accreditation Council for Continuing Medical Education to require organizations that apply for joint providership for accreditation of Continuing Medical Education activities to disclose on its application if the activity has previously been denied accreditation and the reason for denial (Directive to Take Action); and be it further  RESOLVED, That our AMA urge the Accreditation Council for Continuing Medical Education to develop a national database for this information (in a manner similar to the Program and Activity Reporting System) which would allow State Medical Societies providers to cross-reference this information. (Directive to Take Action) |
| D | Res. 401 | Washington | Metered Dose Inhalers and Greenhouse Gas Emissions | RESOLVED, That our American Medical Association study the climate effects of metered-dose inhalers, options for reducing hydrofluorocarbon use in the medical sector, and strategies for encouraging the development of alternative inhalers with equal efficacy and less adverse effect on our climate. (Directive to Take Action) |
| D | Res. 402 | Young Physicians Section | Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance | RESOLVED, That our American Medical Association work with other stakeholders to encourage discussion of family planning counseling with all individuals with reproductive potential as part of routine health maintenance. (Directive to Take Action) |
| D | Res. 403 | Medical Student Section | Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers | RESOLVED, That our American Medical Association policy H-430.983 be amended by addition and deletion to read as follows:  ~~Reducing~~ Opposing the Use of Restrictive Housing ~~in~~ for Prisoners ~~with Mental Illness~~ H-430.983  Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for as short a time as possible; ~~and~~ (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ (Modify Current Policy) |
| D | Res. 404 | Medical Student Section | Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers | RESOLVED, That our American Medical Association amend Policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by addition to read as follows:  HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872  1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.  2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.  3. Our AMA:  (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits,  (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations,  (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.  4. Our AMA will encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.  5. Our AMA will study requiring HPV vaccination for school attendance.  6. Our AMA encourages collaboration with stakeholders to provide human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA amend policy H-55.971, "Screening and Treatment for Breast and Cervical Cancer Risk Reduction", by addition and deletion to read as follows:  Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971  1. Our AMA supports programs to screen all ~~women~~ individuals with relevant anatomy for breast and cervical cancer and that government funded programs be available for low income ~~women~~ individuals; the development of public information and educational programs with the goal of informing all ~~women~~ individuals with relevant anatomy about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income ~~women~~ individuals for breast and cervical cancer and to assure access to definitive treatment.  2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.  3. Our AMA encourages efforts by the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies in an effort to expand coverage for HPV testing including but not limited to in-office primary HPV testing. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA support further research by relevant stakeholders of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening. (New HOD Policy) |
| D | Res. 405 | Medical Student Section | Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972” to Include Medical Professionals as a Party Who Can Petition the Court | RESOLVED, That our American Medical Association work with relevant stakeholders to develop state-specific training programs for medical professionals on how to use Extreme Risk Protection Order/Red Flag Laws (Directive to Take Action); and be it further  RESOLVED, That our AMA work with relevant stakeholders to update medical curricula with training surrounding how to approach conversations about Extreme Risk Protection Order/Red Flag laws with patients and families (Directive to Take Action); and be it further  RESOLVED, That our AMA support amending policy “Firearms and High-Risk Individuals H-145.972” by addition to read as follows:  Firearms and High-Risk Individuals H-145.972  Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and state, federal, and tribal law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) the establishment of laws and procedures through which physicians and other medical professionals can, in partnership with appropriate stakeholders, contribute to the inception and development of such petitions; ~~(2)~~(3) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; ~~(3)~~(4) expanding domestic violence restraining orders to include dating partners; ~~(4)~~(5) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; ~~(5)~~(6) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and ~~(6)~~(7) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (Modify Current HOD Policy) |
| D | Res. 406 | Medical Student Section | Increase Employment Services Funding for People with Disabilities | RESOLVED, That our American Medical Association support increased resources for employment services to reduce health disparities for people with disabilities. (New HOD Policy) |
| D | Res. 407 | Medical Student Section | Addressing Inequity in Onsite Wastewater Treatment | RESOLVED, That our American Medical Association support that federal, state, and local governments abate individual financial and criminal penalties for insufficient wastewater management, especially those placed on underserved communities and American Indian reservations due to environmental racism and socioeconomic disparities (New HOD Policy); and be it further  RESOLVED, That our AMA support research by federal, state, and local governments to develop strategies to reduce insufficient wastewater management and eliminate detrimental health effects due to inadequate wastewater systems. (New HOD Policy) |
| D | Res. 408 | Medical Student Section | School-to-Prison Pipeline | RESOLVED, That our American Medical Association amend H-60.900 by addition to read as follows:  Student-Centered Approaches for Reforming School Disciplinary Policies H-60.900  Our AMA supports:  (1) evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; ~~and~~  (2) the consultation with school-based mental health professionals in the student discipline process~~.~~;  (3) efforts to address physical and mental trauma experienced by children in K-12 education by reducing disproportionate punitive disciplinary actions and the involvement of law enforcement in student discipline;  (4) transitions to restorative approaches that individually address students’ medical, social, and educational needs;  (5) ensuring that any law enforcement presence in K-12 schools focuses on maintaining student and staff safety and not on disciplining students; and  (6) limiting the presence of law enforcement patrolling in schools to only those settings and times where student and staff safety is at active risk. (Modify Current HOD Policy) |
| D | Res. 409 | Medical Student Section | Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training | RESOLVED, That our American Medical Association support use of diverse mannequins in CPR and AED training, including, but not limited to, mannequins with breasts, mannequins representing pregnant persons, mannequins representing persons with disabilities, and mannequins of varying body sizes (New HOD Policy); and be it further  RESOLVED, That our AMA support the efforts of relevant stakeholders to develop diverse mannequins or modify current mannequins to reflect diverse patient populations, including, but not limited to, those representing pregnant persons or persons with physical disabilities (New HOD Policy); and be it further    RESOLVED, That our AMA collaborate with relevant stakeholders to increase accessibility of CPR and AED training equipment representing diverse gender and body types in basic life support and advanced certified life support programs nationwide to ensure optimal competency for trainees of all education levels. (Directive to Taker Action) |
| D | Res. 410 | Medical Student Section | Formal Transitional Care Program for Children and Youth with Special Health Care Needs | RESOLVED, That our American Medical Association amend policy H-60.974, Children and Youth with Disabilities, by addition and deletion to read as follows, to strengthen our AMA policy and to include a 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:  Children and Youth with Disabilities and with Special Healthcare Need H-60.974  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 healthcare 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. (Modify Current HOD Policy) |
| D | Res. 411 | Medical Student Section | Protecting Workers During Catastrophes | RESOLVED, That our American Medical Association advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment and traveling to and from their place of employment during catastrophes. (Directive to Take Action) |
| D | Res. 412 | Medical Student Section | Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal | RESOLVED, That our American Medical Association amend H-65.964 “Access to Basic Human Services for Transgender Individuals” by addition and deletion to read as follows:  Access to Basic Human Services for Transgender Individuals H-65.964  Our AMA (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; ~~and~~ (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity, and (3) will advocate for the inclusion of waste receptacles in all restrooms, including male designated stalls, for safe and discreet disposal of used menstrual products by people who menstruate. (Modify Current HOD Policy) |
| D | Res. 413 | Medical Student Section | Supporting Intimate Partner and Sexual Violence Safe Leave | RESOLVED, That our American Medical Association recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers safe leave (New HOD Policy); and be it further  RESOLVED, That our AMA amend the existing policy H-420.979, “AMA Statement on Family and Medical Leave to promote inclusivity” by addition to read as follows:  AMA Statement on Family and Medical Leave, H-420.979  Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions and/or concerns for safety. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; ~~and~~ (4) leave for adoption or for foster care leading to adoption; and (5) safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (Modify Current HOD Policy) |
| D | Res. 414 | Medical Student Section | Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population | RESOLVED, That our American Medical Association support the development of regulations and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs (New HOD Policy); and be it further  RESOLVED, That our AMA recognize that stable housing promotes adherence to HIV treatment (New HOD Policy); and be it further  RESOLVED, That our AMA amend current policy H-20.922, “HIV/AIDS as a Global Public Health Priority” by addition and deletion to read as follows:  HIV/AIDS as a Global Public Health Priority H-20.922  In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:  (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;  (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, ~~and~~ patient care, and access to stable housing for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;  (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;  (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;  (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;  (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;  (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;  (8) Supports increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and be it further; and  (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services. (Modify Current HOD Policy) |
| D | Res. 415 | Medical Student Section | Environmental Health Equity in Federally Subsidized Housing | RESOLVED, That our American Medical Association acknowledge the potential adverse health impacts of living in close proximity to a Superfund site (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for mandated disclosure of Superfund site proximity to those purchasing, leasing, or currently residing in housing in close proximity to Superfund sites (Directive to Take Action); and be it further  RESOLVED, That our AMA support efforts of public agencies to study the safety of proposed public housing expansions with respect to pollutant exposure and to expand construction of new public and publicly subsidized housing properties on lands without demonstrated unsafe levels of hazardous pollutants (New HOD Policy); and be it further  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 and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (~~3~~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. (Modify Current HOD Policy) |
| D | Res. 416 | Medical Student Section | New Policies to Respond to the Gun Violence Public Health Crisis | RESOLVED, That our American Medical Association advocate for federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for federal and state policies to prevent “multiple sales” of firearms, defined as the sale of multiple firearms to the same purchaser within five business days (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for federal and state policies implementing background checks for ammunition purchases. (Directive to Take Action) |
| D | Res. 417 | Senior Physicians Section | Treating Social Isolation and Loneliness as a Social Driver of Health | RESOLVED, That our American Medical Association develop educational programs for healthcare professionals and the lay public regarding the significance of social isolation and loneliness to include promoting social connections through community-based programs and encouraging  social participation through volunteering, civic engagement, and community service (Directive to Take Action); and be it further  RESOLVED, That our AMA promote enhancing access, including transportation, to health and social services (Directive to Take Action); and be it further  RESOLVED, That our AMA encourage research to assess how forming networks earlier in life helps to reduce loneliness and social isolation for adults, with a special focus on marginalized populations and communities with limited access to resources (New HOD Policy); and be it further  RESOLVED, That our AMA develop toolkits to help clinicians identify and address social isolation and loneliness as a social driver of health (Directive to Take Action); and be it further  RESOLVED, That our AMA work collaboratively with state medical societies, community-based organizations, social service agencies, and public health departments to promote social connections and enhance social support for patients. (Directive to Take Action) |
| D | Res. 418 | Medical Student Section | Increasing the Availability of Automated External Defibrillators | RESOLVED, That our American Medical Association amend Policy H-130.938, “Cardiopulmonary Resuscitation (CPR) and Defibrillators,” by addition to read as follows:  Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938  Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held; (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events; (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (8) supports the development and use of universal connectivity for all defibrillators; (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use; (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications; (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; ~~and~~ (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim; and~~.~~  (13) encourages the distribution of Automated External Defibrillators in an equitable manner through the utilization of targeted placement strategies in order to increase availability and decrease disparities in areas where disproportionate rates of out-of-hospital cardiac arrest episodes exist. (Modify Current HOD Policy) |
| D | Res. 419 | American Academy of Pediatrics | Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System | RESOLVED, That our American Medical Association amend policy H-60.937, Youth and Young Adult Suicide in the United States, by addition and deletion to read as follows:  Youth and Young Adult Suicide in the United States H-60.937  Our AMA:  1) Recognizes child, youth and young adult suicide as a serious health concern in the US;  2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;  3) Supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide;  4) Encourages efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;  5) Encourages continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system;  6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults;  7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;  8) Will publicly call attention to the escalating crisis in children, youth and young adult ~~and adolescent~~ mental health in this country in the wake of the Covid-19 pandemic;  9) Will advocate at the state and national level for policies to prioritize children’s, youth’s, and young adult’s mental, emotional, and behavioral health;  10) Will advocate for comprehensive system of care including prevention, management, and crisis care to address mental and behavioral health needs for ~~infants~~, children, youth, and young adult ~~and adolescents~~; and  11) Will advocate for a comprehensive approach to the child youth, and young adult ~~and adolescent~~ mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy. (Modify Current HOD Policy) |
| D | Res. 420 | American Academy of Pediatrics | Foster Health Care | RESOLVED, That our American Medical Association amend policy H-60.910, Addressing Healthcare Needs of Children in Foster Care, by addition and deletion to read as follows:  Addressing Healthcare Needs of Children in Foster Care H-60.910  Our AMA advocates for comprehensive, ~~and~~ evidence-based, trauma-informedcare that addresses the specific mental, developmental, and physical health care needs of children in foster care. (Directive to Take Action) |
| D | Res. 421 | American Academy of Child and Adolescent Psychiatry | Prescribing Guided Physical Activity for Depression and Anxiety | RESOLVED, That our American Medical Association study evidence of the efficacy of physical activity interventions (e.g. group fitness, personal training, or physical therapy) on behavioral activation and outcomes on depressive symptoms. (Directive to Take Action) |
| D | Res. 422 | American Academy of Child and Adolescent Psychiatry | National Emergency for Children | RESOLVED, That our American Medical Association declare a national state of emergency in children’s mental health. (New HOD Policy) |
| D | Res. 423 | New England | Reducing Sodium Intake to Improve Public Health | RESOLVED, That our American Medical Association work with all relevant stakeholders to advocate and advise salt reduction through public outreach that may include, but not be limited to, policy changes, ad campaigns, educational programs, including those starting in schools, and food labeling (Directive to Take Action); and be it further  RESOLVED, That our AMA study and report back at the 2024 Annual Meeting the effectiveness and feasibility of salt reduction strategies with specific interventions such as:  1. Consumer awareness and empowerment of populations through social marketing and mobilization to raise awareness of salt alternatives and the need to reduce salt intake  2. Government policies, including appropriate fiscal policies and regulation, to ensure food manufacturers produce healthier affordable low-sodium foods and retailers make such products available  3. Integrating salt reduction strategies and alternatives into the training curriculum of food handlers  4. Removing opportunistic use of saltshakers  5. Introducing and regulating “High in Sodium” (or similar) front-of-pack product labels or prominent shelf labels  6. Automating targeted sodium dietary advice to people visiting health facilities  7. Advocating for people to limit their intake of products high in salt and advocating that they reduce the amount of salt used for cooking  8. Educating and providing a supportive environment for children to encourage early adoption of low salt diets  9. Reducing salt in food served by restaurants and catering outlets, and labelling the sodium content of this food. (Directive to Take Action) |
| D | Res. 424 | American Academy of Pediatrics | Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home | RESOLVED, That our American Medical Association amend H-420.979, AMA Statement on Family and Medical Leave, by addition and deletion to read as follows:  AMA Statement on Family and Medical Leave H-420.979  Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:  1) Medical leave for the employee, including pregnancy, abortion, and stillbirth;  2) Maternity leave for the employee-mother;  3) Leave if medically appropriate to care for a member of the employee’s immediate family, i.e., a spouse or children; and  4) Leave for adoption or for ~~foster~~ placement of a child in foster care in the home ~~leading to adoption~~. Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (Modify Current HOD Policy) |
| D | Res. 425 | Minnesota | Examining Policing Through a Public Health Lens | RESOLVED, That our American Medical Association advocate for research to be conducted that examines the public health consequences of negative police interactions (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for a change to the U.S. Standard Certificate of Death to include a “check box” that would categorize deaths in custody and would create a new statistical grouping with explanations of the range of causes, manner and circumstances of death, within the spectrum of police custody, corrections custody, and legal custody. (Directive to Take Action) |
| D | Res. 426 | Eppes, Delegate | Accurate Abortion Reporting with Demographics by the Center for Disease Control | RESOLVED, That our American Medical Association call upon the Center for Disease Control (CDC) to develop and mandate collection of abortion statistics from each state that at minimum include the following data:  1) Age of the woman.  2) Race of the woman.  3) Facility [Hospital, Ambulatory Surgery Center, Private Center meeting ASC standards, Private Center not meeting ASC standards.  4) Gestational age of pregnancy.  5) The abortion procedure or medication chosen.  6) Reason for abortion [life of the mother, rape, incest, choice].  7) Miles traveled to obtain the abortion and whether the woman had to go out of state due to state laws prohibiting abortion care. |
| D | Res. 427 | Delaware | Minimizing the Influence of Social Media on Gun Violence | RESOLVED, That our American Medical Association call upon all social media sites and all others that allow posting of videos, photographs, and written online comments encouraging and glorifying the use of guns and gun violence to vigorously and aggressively remove such postings (Directive to Take Action); and be it further  RESOLVED, That our AMA strongly recommend social media sites continuously update and monitor their algorithms in order to detect and eliminate any information that discusses and displays guns and gun violence in a way that encourages viewers to act violently (New HOD Policy); and be it further  RESOLVED, That our AMA work with social media sites to provide educational content on the use of guns, inherent dangers, and gun safety in an effort to end the ongoing and devastating effects of gun violence in our communities. (Directive to Take Action) |
| D | Res. 428 | Organized Medical Staff Section | Mattress Safety in the Hospital Setting | RESOLVED, That our American Medical Association work with the accrediting bodies and interested stakeholders to make sure all possible appropriate care and maintenance measures be undertaken to mitigate infection related to hospital bed and mattress use (Directive to Take Action) |
| D | Res. 429 | American Association of Public Health Physicians | Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System | RESOLVED, That our American Medical Association support the following qualifications for the Director and Assistant Director of the Federal Bureau of Prisons positions and other administrators supervising physicians and other clinical staff within its facilities:  1. MD or DO, MBSS, degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting.  2. Knowledge of health disparities among Black, Indigenous, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.  3. Knowledge of the health disparities among individuals who are involved with the criminal justice system (New HOD Policy); and be it further  RESOLVED, That our AMA initiate a public health campaign or appropriate effort to promote the highest quality of healthcare and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles. (Directive to Take Action) |
| D | Res. 430 | Hsu, Delegate | Teens and Social Media | RESOLVED, That our American Medical Association study and make recommendations for age limits on teenage use of social media, including proposing model state and federal legislation as needed, with a report back at the 2024 Annual Meeting. (Directive to Take Action) |
| D | Res. 431 | Minority Affairs Section | Qualified Immunity Reform | RESOLVED, That our American Medical Association recognize the way we police our communities is a social determinant of health (New HOD Policy); and be it further  RESOLVED, That our AMA advocate for the reform of qualified immunity and other measures that shield law enforcement officers from consequences of misconduct to further address systemic racism in policing and mitigate use of excessive force. (Directive to Take Action) |
| E | Res. 501 | Medical Student Section | AMA Study of Chemical Castration in Incarceration | RESOLVED, That our American Medical Association study the use of chemical castration in the treatment of incarcerated individuals with paraphilic disorders and for other individuals who commit sexual offenses, including ethical concerns over coercion in its use as an alternative to incarceration and in probation and parole proceedings. (Directive to Take Action) |
| E | Res. 502 | Medical Student Section | Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures | RESOLVED, That our American Medical Association recognize the disparity in pain management in gynecological procedures compared to procedures of similarly reported pain and encourages discussion of pain control options, risks, and benefits with patients as a part of the shared decision making process (New HOD Policy); and be it further  RESOLVED, That our AMA support further research into evidence-based anesthetic and anxiolytic medication options for long-acting reversible contraception procedures and other gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and LEEP procedures. (New HOD Policy) |
| E | Res. 503 | Medical Student Section | Increasing Diversity in Stem Cell Biobanks and Disease Models | RESOLVED, That our American Medical Association encourage research institutions and stakeholders to re-evaluate recruitment strategies and materials to encourage participation by underrepresented populations (New HOD Policy); and it be further  RESOLVED, That our AMA amend Policy H-460.915, “Cloning and Stem Cell Research,” by addition to read as follows:  Cloning and Stem Cell Research, H-460.915  Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood stem cells); (2) urges the use of stem cell lines from different ethnicities in disease models; ~~(2)~~(3) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); ~~(3)~~(4) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); ~~(4)~~(5) encourages strong public support of federal funding for research involving human pluripotent stem cells and ~~(5)~~(6) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA strongly encourage institutional biobanks to collect racially and ethnically diverse samples such that future induced pluripotent stem cell disease models better represent the population. (New HOD Policy) |
| E | Res. 504 | American Society for Surgery of the Hand | Regulating Misleading AI Generated Advice to Patients | Reassigned to Reference Committee B. Now Resolution 256 |
| E | Res. 505 | Medical Student Section | Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations | RESOLVED, That our American Medical Association amend Policy H-95.932, “Increasing Availability of Naloxone”, by addition to read as follows:  Increasing Availability of Naloxone H-95.932  1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.  2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.  3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.  4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.  5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.  6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.  7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.  8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.  9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.  10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order naloxone to help prevent opioid-related overdose, especially in underserved communities and American Indian reservations. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA amend Policy H-420.950, “Substance Use Disorders During Pregnancy” by addition to read as follows:  Substance Use Disorders During Pregnancy H-420.950  Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; ~~and~~ (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual’s family structure, (b) the patient’s treatment status, and (c) current impairment status when substance use is suspected, and (5) support universal opioid use screenings at prenatal care visits with early intervention, comprehensive naloxone use education and distribution for those who screen positive and following overdose-related emergency department visits. (Modify Current HOD Policy); and be it further  RESOLVED, That our AMA amend D-95.987, “Prevention of Drug-Related Overdose” by addition to read as follows:  Prevention of Drug-Related Overdose D-95.987  1. Our AMA: (a) recognizes the great burden that 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; (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 AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug- related overdose; ~~and~~ (b) support the development of adjuncts and alternatives to naloxone to combat synthetic opioid-induced respiratory depression and overdose; and (c) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.  3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.  4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.  5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.  6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction. (Modify Current HOD Policy) |
| E | Res. 506 | Medical Student Section | Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development | Reassigned to Reference Committee F. Now Resolution 609 |
| E | Res. 507 | Medical Student Section | Recognizing the Burden of Rare Disease | RESOLVED, That our American Medical Association recognize the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems and affected individuals, and the health disparities among patients with orphan diseases (New HOD Policy); and be it further  RESOLVED, That our AMA support efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies to develop novel therapeutics to better understand and treat orphan diseases. (New HOD Policy) |
| E | Res. 508 | Medical Student Section | Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses | RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of opioid drug overdoses. (New HOD Policy) |
| E | Res. 509 | Medical Student Section | Addressing Medical Misinformation Online | RESOLVED, That our American Medical Association policy D-440.915 be amended by addition and deletion to read as follows:  Medical and Public Health Misinformation in the ~~Age of Social Media~~Online D-440.915  Our AMA:  (1) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information;  (2) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health 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;  (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and  (4) will 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 and public health information. |
| E | Res. 510 | Medical Student Section | Comparative Effectiveness Research | RESOLVED, That our American Medical Association study the feasibility of including comparative effectiveness studies in various FDA drug regulatory processes, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter (Directive to Take Action); and be it further  RESOLVED, That our AMA ask the National Institutes of Health to support and fund comparative effectiveness research for approved drugs, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter. (Directive to Take Action) |
| E | Res. 511 | Medical Student Section | Regulation of Phthalates in Adult Personal Sexual Products | RESOLVED, That our American Medical Association amend policy H-135.945 by addition and deletion to read as follows:  Encouraging Alternatives to PVC/Phthalate ~~DEHP~~ Products in Health H-135.945  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;  (3) encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of 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. (Modify Current HOD Policy) |
| E | Res. 512 | American Academy of Physical Medicine & Rehabilitation | Wheelchairs on Airplanes | RESOLVED, That our American Medical Association encourage Congress and the FAA to change the rules for commercial flights so that modifications must be made to planes to allow passengers whose only means of mobility is the wheelchair to stay in their personal wheelchairs during flight and while entering and exiting the plane. (New HOD Policy) |
| E | Res. 513 | American Academy of Child and Adolescent Psychiatry | Substance Use History is Medical History | RESOLVED, That our American Medical Association support that substance use history is part of the medical history and should be documented in the medical history section of a patient’s health record (New HOD Policy); and be it further  RESOLVED, That our AMA support that all medical schools train medical students to take a thorough and nonjudgmental substance use history as part of a patient’s medical history (New HOD Policy); and be it further  RESOLVED, That our AMA work with relevant stakeholders to advocate for electronic health record vendors to modify their software to allow for substance use history to be documented in the past medical history and to move the substance use history from the social history section of electronic health record technology. (Directive to Take Action) |
| E | Res. 514 | American Academy of Child and Adolescent Psychiatry | Adolescent Hallucinogen-Assisted Therapy Policy | RESOLVED, That our American Medical Association advocate against the use of psychedelics to treat any psychiatric disorder except within the context of approved investigational studies (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for continued research and therapeutic discovery into psychedelic agents with the same scientific integrity and regulatory standards applied to other promising therapies in medicine. (Directive to Take Action) |
| E | Res. 515 | Mississippi | Regulate Kratom and Ban Over-The-Counter Sales | RESOLVED, That our American Medical Association recommend the following:  1. Kratom should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as a treatment for any condition.  2. Over-the-counter sales of kratom should be banned, and kratom should be available only by prescription from a licensed healthcare provider if it is deemed to have a medicinal use after proper research.  3. Individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.  4. Criminalization of kratom use should not be the intent of this resolution, and individuals who are using kratom for legitimate medical reasons should not be subject to criminal penalties although if it is banned, this does not exclude criminalization of drug trafficking.  5. The Drug Enforcement Administration should conduct a comprehensive review of the potential for kratom abuse and dependence and consider appropriate scheduling under the Controlled Substances Act. A schedule 3 would make it unavailable over the counter but avoid criminal penalties.  6. Research funding should be made available to study the potential therapeutic uses and risks of kratom, and to develop evidence-based guidelines for its safe use.  7. Education and public awareness campaigns should be launched to inform healthcare providers, patients, and the general public about the potential risks and benefits of kratom and the need for caution in its use. (New HOD Policy) |
| E | Res. 516 | Senior Physicians Section | Fasting is Not Required for Lipid Analysis | RESOLVED, That our American Medical Association develop educational programs affirming that fasting is not required for lipid analysis. (Directive to Take Action) |
| E | Res. 517 | New Jersey | Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States | RESOLVED, That our American Medical Association support and advocate for additional NIH funding to study disparities in population health due to genetic predispositions, which lead to diseases with high morbidity such as cardiovascular disease in South Asian patients (Directive to Take Action); and be if further  RESOLVED, That our AMA encourage the development of collaborative partnerships with other organizations, institutions, policymakers, and stakeholders to reduce health disparities arising from genetic predispositions and any accompanying cultural and linguistic barriers, through the creation of educational campaigns and outreach programs. (New HOD Policy) |
| E | Res. 518 | American Thoracic Society | Defending NIH Funding of Animal Model Research From Legal Challenges | RESOLVED, That our American Medical Association join other medical professional societies in an amicus brief supporting that National Institutes of Health’s decision to fund grants to study sepsis in rodent animal models (Directive to Take Action); and be it further  RESOLVED, That our AMA reaffirm its support of the use of animal model research that abides by National Institutes of Health’s ethical guides on the use of animals in research. (New HOD Policy) |
| E | Res. 519 | GLMA: Health Professionals Advancing LGBTQ+ Equality | Rescheduling or Descheduling Testosterone | RESOLVED, That our American Medical Association urge the United States Drug Enforcement Administration to reschedule or deschedule testosterone as a Schedule III substance. (New HOD Policy) |
| E | Res. 520 | Illinois | Supporting Access to At-Home Injectable Contraceptives | RESOLVED, That our American Medical Association support access to at-home contraceptive injections as a method of birth control for women across the nation. (New HOD Policy) |
| E | Res. 521 | Illinois | Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs | RESOLVED, That our American Medical Association support the continued inclusion of cannabis metabolite analysis in all urine/hair/oral fluid drug testing analysis performed for occupational and municipal purposes (pre-employment, post-accident, random and for-cause). (New HOD Policy) |
| E | Res. 522 | Association for Clinical Oncology | Approval Authority of the FDA | RESOLVED, That our American Medical Association consider filing an amicus brief if a mifepristone-access case is formally heard at the Supreme Court to allow the Food and Drug Administration (FDA) to continue its mission of providing safe and effective drugs without political or ideological interference. (Directive to Take Action) |
| E | Res. 523 | Indiana | Reducing Youth Abuse of Dextromethorphan | RESOLVED, That our American Medical Association seek and support methods to reduce the sale of products containing dextromethorphan to minors. (Directive to Take Action) |
| E | Res. 524 | New York | Ensuring Access to Reproductive Health Services Medications | RESOLVED, That our American Medical Association advocate and support the continuation of the Food and Drug Administration’s authority to determine whether drugs are safe and effective (Directive to Take Action); and be it further  RESOLVED, That our AMA support legal efforts to ensure that mifepristone and misoprostol are available to anyone for whom they are prescribed (New HOD Policy); and be it further  RESOLVED, That our AMA support efforts, including joining in an Amicus Brief, to ensure that both these medications continue to be available, and that the FDA retain its regulatory authority. (Directive to Take Action) |
| F | Res. 601 | Resident and Fellow Section | Solicitation Using the AMA Brand | RESOLVED, That our American Medical Association study the use of AMA branded solicitation material mailed to physicians, the impact it has on the perception of our AMA by current and potential physician members, and the merits of continuing to use these materials in future communications (Directive to Take Action); and be it further  RESOLVED, That our American Medical Association survey our membership on the preferred method to receive third-party solicitation material (mail, phone, email, social media) and provide a method to opt-out of certain methods if not desired. (Directive to Take Action) |
| F | Res. 602 | Medical Student Section | Supporting the Use of Gender-Neutral Language | RESOLVED, That our American Medical Association (1) Recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) revise all relevant policies to utilize gender-neutral language in place of gendered language where such text inappropriately appears, (3) utilize gender-neutral language in future policies, internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. (New HOD Policy) |
| F | Res. 603 | Medical Student Section | Environmental Sustainability of AMA National Meetings | RESOLVED, That our American Medical Association commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization, and report annually on the AMA's progress towards implementation (New HOD Policy); and be it further  RESOLVED, That our AMA work with appropriate stakeholders to encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization, including by creating educational materials (Directive to Take Action); and be it further  RESOLVED, That our AMA evaluate the feasibility of purchasing carbon offsets for members traveling to and from Annual and Interim meetings and report back to the House of Delegates (Directive to Take Action); and be it further  RESOLVED, That our AMA evaluate the feasibility of holding future Annual and Interim meetings at Leadership in Energy and Environmental Design-certified or sustainable conference centers and report back to the House of Delegates. (Directive to Take Action) |
| F | Res. 604 | American Academy of Physical Medicine and Rehabilitation | Speakers Task Force to Review and Modernize the Resolution Process | RESOLVED, That our American Medical Association form a Speakers Task Force on the Resolution Process to review the entire process of handling resolutions for our AMA House of Delegates, including but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions, deadlines for submission of resolutions by all sections, processing and review of reference committee reports, and use of virtual meetings so that all on time resolutions can be submitted by the same deadline (Directive to Take Action); and be it further  RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back to our AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the resolution process. (Directive to Take Action) |
| F | Res. 605 | International Medical Graduates Section | Equity and Justice Initiatives for International Medical Graduates | RESOLVED, That our American Medical Association, via the Center for Health Equity, create a yearly session (during the Interim or Annual Meeting) as a part of the equity forum that will be dedicated to international medical graduates (Directive to Take Action); and be it further  RESOLVED, That our AMA, via the Center of Health Equity, create an amendment to the health equity plan that will address the issues of equity and justice for international medical graduates. (Directive to Take Action) |
| F | Res. 606 | Georgia | AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates | RESOLVED, That our American Medical Association develop a reimbursement policy consistent with established AMA travel policies for reasonable travel expenses that any state or national specialty society is eligible to receive reimbursement for its delegate’s and alternate delegate’s actual expenses directly related to the necessary business functions required of its AMA delegates and alternate delegates in service to the AMA at HOD meetings, including travel, lodging, and meals (Directive to Take Action); and be it further  RESOLVED, That each state or national specialty society requesting such reimbursement for its delegate’s and alternate delegate’s reasonable travel expenses will submit its own aggregated documentation to the AMA in whatever form is requested by the AMA. (Directive to Take Action) |
| F | Res. 607 | Gold, Delegate | Enabling Sections of the American Medical Association | RESOLVED, That our American Medical Association Section meetings be held officially over no less than two calendar days in anticipation of general House of Delegates meetings, unless otherwise determined by a given individual Section. (Directive to Take Action) |
| F | Res. 608 | Illinois | Supporting Carbon Offset Programs for Travel for AMA Conferences | RESOLVED, That our American Medical Association facilitate the mitigation or offset of carbon emissions related to AMA events, including planning and management, travel, and conference operations, by procurement of sustainable or otherwise carbon-neutral energy, travel services, supplies, etc. under the direct control of the AMA and provision for conference attendees and other external stakeholders to access the equivalent mitigation or offsets for their own attendance and related activities. Mitigation and offset measures may include purchase of renewable energy credits, sustainable purchasing requirements integrating emissions criteria, investment in forestry and conservation, energy efficiency projects, or other instruments traded by accredited entities. (Directive to Take Action) |
| F | Res. 609 | Medical Student Section | Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development | RESOLVED, That our American Medical Association augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on:  (1) Expanding recruitment among AMA physician members,  (2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas,  (3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies,  (4) Facilitating communication between companies and physicians with similar interests,  (5) Matching physicians to projects early in their design and testing stages,  (6) Decreasing the time and workload spent by individual physicians on finding projects themselves,  (7) Above all, boosting physician-centered innovation in the field of AI research and development (Directive to Take Action); and be it further  RESOLVED, That our AMA support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry. (New HOD Policy) |
| G | Res. 701 | Medical Student Section | Reconsideration of the Birthday Rule | RESOLVED, That our American Medical Association support evidence-based legislation that support a parent, or guardian’s, choice of their dependent’s health insurance plan under the event of multiple insurers (New HOD Policy); and be it further  RESOLVED, That our AMA amend Policy H-190.969: "Delay in Payments Due to Disputes in Coordination of Benefits" by addition to read as follows:  Delay in Payments Due to Disputes in Coordination of Benefits, H-190.969  Our AMA:  (1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;  (2) includes the "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;  (3) urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;  (4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;  (5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;  (6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and  (7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services. (Modify Current HOD Policy) |
| G | Res. 702 | Medical Student Section | Providing Reduced Parking for Patients | RESOLVED, That our American Medical Association work with relevant stakeholders to recognize parking fees as a barrier to patient care and encourage mechanisms for reducing parking costs for patients and trainees. (New HOD Policy) |
| G | Res. 703 | Medical Student Section | Tribal Health Program Electronic Health Record Modernization | RESOLVED, That our American Medical Association support adequate funding for electronic health record modernization and maintenance costs for Tribal and Urban Indian Health Programs with active self-governance compacts and contracts with the Indian Health Service. (New HOD Policy) |
| G | Res. 704 | Medical Student Section | Interrupted Patient Sleep | RESOLVED, That our American Medical Association encourage physicians, trainees, inpatient care teams, and hospital administration to reduce the number of patient sleep interruptions as much as possible, including considering the impact of circadian and environmental factors on sleep, to only those interruptions which are necessary and cannot be performed at another time (New HOD Policy); and be it further  RESOLVED, That our AMA support efforts to improve quality, duration, and timing of inpatient sleep. (New HOD Policy) |
| G | Res. 705 | Senior Physicians Section | Aging and Dementia Friendly Health Systems | RESOLVED, That our American Medical Association lobby Congress, state legislatures and appropriate organizations to expand community and home-based services to promote and support “aging in place” (Directive to Take Action); and be it further  RESOLVED, That our AMA develop educational resources for all health care professionals about ways that successful outcomes have been achieved to appropriately support patients as they age including those with dementia both in their homes as well as in health care systems. (Directive to Take Action) |
| G | Res. 706 | Medical Student Section | Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis | RESOLVED, That our American Medical Association support research towards the evaluation and the development of interventions and programs for autistic individuals (New HOD Policy); and be it further  RESOLVED, That our AMA work with relevant stakeholders to advocate for a comprehensive spectrum of primary and specialty care that recognizes the diversity and personhood of individuals who are neurodivergent, including people with autism (Directive to Take Action); and be it further  RESOLVED, That our AMA amend Policy H-185.921 "Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" by addition and deletion as follows:  Standardizing Coverage ~~of Applied Behavioural Analysts Therapy~~ for Persons with Autism Spectrum Disorder, H-185.921  Our AMA supports coverage and reimbursement for evidence-based ~~treatment of~~ services for Autism Spectrum Disorder ~~including, but not limited to, Applied Behavior Analysis Therapy~~. (Modify Current HOD Policy) |
| G | Res. 707 | American Academy of Physical Medicine & Rehabilitation | Expediting Repairs for Power and Manual Wheelchairs | RESOLVED, That our American Medical Association encourage all payors to improve the process of and reduce barriers to patients obtaining wheelchair repairs for patient-owned power and manual wheelchairs, to ensure that repairs and services are safe, affordable, and timely, and support mobility and independence for those who utilize power and manual wheelchairs (New HOD Policy); and be it further  RESOLVED, That our AMA encourage all payors to eliminate unnecessary paperwork including requiring prior authorization for basic repairs and proof of continuous need for patient-owned power and manual wheelchairs (New HOD Policy); and be it further  RESOLVED, That our AMA encourage all payors to add coverage and payment for  (1) temporary rental of a substitute wheelchair when repairs require the primary wheelchair to be taken out of the home;  (2) preventive maintenance; and  (3) travel to and from the patient’s home when the patient cannot transport the wheelchair to a repair facility (New HOD Policy); and be it further  RESOLVED, That our AMA encourage all suppliers of power and manual wheelchairs to service wheelchairs they supply to patients and to permit consumers to perform simple self-repairs and have access to necessary parts. (New HOD Policy) |
| G | Res. 708 | American College of Gastroenterology | UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures | RESOLVED, That our American Medical Association strongly advocate with all state and federal agencies for the cancellation of UHC’s 2023 blanket prior authorization policy directed at endoscopic procedures in favor of a directed utilization review of presumed outliers (Directive to Take Action); and be it further  RESOLVED, That our AMA redouble its efforts to promote state laws such as the AMA’s example “Ensuring Transparency in Prior Authorization Act” (Directive to Take Action); and be it further  RESOLVED, That our AMA communicate with the various state insurance commissioners concerning UHC’s prior authorization policy change, which has the potential to adversely affect access, quality, and equity of G.I. patient care. (Directive to Take Action) |
| G | Res. 709 | Medical Student Section | Hospital Bans on Trial of Labor After Cesarean | RESOLVED, That our American Medical Association support the elimination of broad hospital-based restrictions that prevent physicians from offering a trial of labor after cesarean to their patients when medically appropriate (New HOD Policy); and be it further  RESOLVED, That our AMA encourage hospitals to establish clear and transparent policies on trial of labor after cesarean in order to improve the process of patient-physician shared decision-making. (New HOD Policy) |
| G | Res. 710 | Michigan | Protect Patients with Medical Debt Burden | RESOLVED, That our American Medical Association work with the appropriate national organizations to address the medical debt crisis by advocating for robust policies at the federal and state level that prevent medical debt, help consumers avoid court involvement, and ensure that court involved cases do not result in devastating consequences to patients' employment, physical health, mental wellbeing, housing, and economic stability. (Directive to Take Action) |
| G | Res. 711 | Missouri | Doctors’ Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs | RESOLVED, That the American Medical Association work with medical liability insurers and medical care facilities to discourage the termination of liability coverage or clinical privileges of any physician who has been charged with a crime arising from the provision of evidence-based healthcare. (Directive to Take Action) |
| G | Res. 712 | New Jersey | Medical Bankruptcy – A Unique Feature in the USA | RESOLVED, That our American Medical Association study the causes of medical bankruptcy in the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with such report to include recommendations to the House of Delegates to severely reduce the problem of medical debt. (Directive to Take Action) |
| G | Res. 713 | American Academy of Hospice and Palliative Medicine | Redesigning the Medicare Hospice Benefit | RESOLVED, That Our American Medical Association advocate for a 21st century evolution of the Medicare hospice benefit that meets the quadruple aim of health care; advances health equity; and improves access, support, and outcomes for seriously ill patients across all geographies, including underserved and low-resource communities (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate for a reformed Medicare hospice benefit that incorporates the following components:  1) Hospice eligibility should not be based solely on a specified prognosis or life expectancy but rather on patients’ needs; patients with unclear prognoses should be able to access hospice services if their need is otherwise established.  2) Patients must continue to have an open choice of hospice providers.  3) Hospice services, including telehealth or telemedicine, should be provided by a full, physician-led interdisciplinary team.  4) Patients and their caregivers should receive adequate support using home- or facility-based hospice services, identified by a thorough assessment of their social determinants of health. This would incorporate 24-hour a day care for beneficiaries with very limited life expectancy who lack around-the-clock caregivers.  5) Patients should have concurrent access to disease-directed treatments along with palliative services.  6) Payments to hospices should be sufficient to support the quality, experience, scope, and frequency of care that beneficiaries deserve throughout the later stages of serious illness as dictated by their physical, psychological, social, spiritual, and practical needs.  7) The hospice benefit should be consistent, including with regard to the quality and intensity of services, regardless of which Medicare program or entity pays for services.  8) Metrics for health provider accountability should focus on those aspects of care and experience that matter most to patients, families, and caregivers. (Directive to Take Action) |
| G | Res. 714 | American Academy of Hospice & Palliative Medicine | Improving Hospice Program Integrity | RESOLVED, That our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) use its existing authority to limit certification of additional hospices in counties where growth in hospice programs is out of line with established need by implementing a temporary targeted moratorium based on federal and state data, allowing for appropriate exceptions to ensure continued access to care (Directive to Take Action); and be it further  RESOLVED, That Our AMA advocate that CMS strengthen investigation prior to approval of initial hospice certification applications and, for those new hospices approved but identified as high risk, require enhanced scrutiny and/or survey frequency (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that CMS use its existing authority to prohibit the sale or transfer of Medicare hospice certification numbers for a specified timeframe (similar to the 36-month change of ownership prohibition in the Medicare home health program), allowing for appropriate exceptions to ensure continued access to care (Directive to Take Action); and be it further  RESOLVED, That Our AMA advocate that CMS restrict Medicare privileges for non-operational hospices, including through voluntary termination of the provider agreement, deactivation of billing privileges, and revocation of Medicare enrollment (Directive to Take Action); and be it further  RESOLVED, That Our AMA advocate that CMS regulatory efforts aimed at weeding out fraud, waste, and abuse be refocused on integrity and quality indicators that impact patient care – rather than technical errors and retrospective chart audits focused on questioning eligibility – and avoid blunt instruments that burden high-performing programs, divert time and resources from patient care, and risk driving smaller providers from the market and/or putting rural or frontier hospice programs at a disadvantage. (Directive to Take Action) |
| G | Res. 715 | American Association of Neurological Surgeons | Published Metrics for Hospitals and Hospital Systems | RESOLVED, That our American Medical Association identify transparency metrics, such as physician retention and physician satisfaction, that would apply to hospitals and hospital systems and report back with recommendations for implementing appropriate processes to require the development and public release of such transparency metrics. (Directive to Take Action) |
| G | Res. 716 | American Association of Neurological Surgeons | Transparency and Accountability of Hospitals and Hospital Systems | RESOLVED, That our American Medical Association identify options for developing and implementing processes — including increased transparency of physician complaints made to the Equal Employment Opportunity Commission and The Joint Commission — for tracking and monitoring physician complaints against hospitals and hospitals systems and report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act of 1986 to include monetary penalties for institutions performing bad-faith peer reviews. (Directive to Take Action) |
| G | Res. 717 | American College of Chest Physicians | Improving Patient Access to Supplemental Oxygen Therapies | RESOLVED, That our American Medical Association advocate for the adoption of a CMS-crafted, patient- and provider- endorsed, clinical template in lieu of medical record review to maintain patient access to supplemental oxygen (Directive to Take Action); and be it further  RESOLVED, That our AMA, to ensure predictable reimbursement and establish medical necessity, advocate for CMS to establish a CMS-crafted, patient- and provider- endorsed, clinical template as the national standard documentation for supplemental oxygen suppliers. (Directive to Take Action) |
| G | Res. 718 | Georgia | Insurance Coverage of FDA Approved Medications and Devices | RESOLVED, That our American Medical Association support prohibiting the use of the rationale for denial that a medication or device is experimental by insurance companies where such medication or device has been approved by the United States Food and Drug Administration for one year or longer and has peer-reviewed evidence supporting its use in the manner in which it was prescribed. (New HOD Policy) |
| G | Res. 719 | Illinois | Care Partner Access to Medical Records | RESOLVED, That our American Medical Association advocate that electronic health records (EHR) vendors offer simplified procedures for granting proxy access to care partners (or caregivers) to the electronic health record, including online registration with multifactor authentication to promote security, rather than requiring in person registration (Directive to Take Action); and be it further  RESOLVED, That our AMA advocate that vendors develop a simple mechanism for noting and displaying care partner names and contact information in the Electronic Health Record (EHR), along with privacy settings that allow patients to grant proxy access to selected portions of their records, including easy to understand information on use of this information and a user-friendly consent mechanism (Directive to Take Action); and be it further  RESOLVED, That our AMA support and encourage Congress to modernize Health Insurance Portability and Accountability Act (HIPAA) laws to ensure that HIPAA rules for preserving the privacy of patient and associated data also cover third party applications’ access to electronic health records (EHRs). (New HOD Policy) |
| G | Res. 720 | Association for Clinical Oncology | Prior Authorization Costs, AMA Update to CMS | RESOLVED, That our American Medical Association include the costs associated with prior authorization in the practice expense data and methodology information submitted to the Centers for Medicare & Medicaid Services. (Directive to Take Action) |
| G | Res. 721 | American Society for Gastrointestinal Endoscopy | Use of Artificial Intelligence for Prior Authorization | RESOLVED, That our American Medical Association advocate for greater regulatory oversight of the use of artificial intelligence for review of patient claims, including whether insurers are using a thorough and fair process that includes reviews by doctors and other health care professionals with expertise for the service under review, and that such reviews include human examination of patient records prior to a care denial. (Directive to Take Action) |
| G | Res. 722 | New York | Expanding Protections of End-Of-Life Care | RESOLVED, That our American Medical Association:  (1) recognizes that healthcare, including end of life care like hospice, is a human right;  (2) supports the education of medical students, residents and physicians about the need for physicians who provide end of life healthcare services;  (3) supports the medical and public health importance of access to safe end of life healthcare services and the medical, ethical, legal and psychological principles associated with end-of-life care;  (4) supports education of physicians and lay people about the importance of offering medications to treat distressing symptoms associated with end of life including dyspnea, air hunger, and pain;  (5) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to end-of-life care;  (6) supports shared decision-making between patients and their physicians regarding end-of-life healthcare;  (7) opposes limitations on access to evidence-based end of life care services;  (8) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for receiving, assisting in, referring patients to, or providing end of life healthcare services. (New HOD Policy) |

† Only the first organization is listed for those resolutions sponsored by multiple entities